Haymarket General Practice: Referral Form

Date Completed:

Date of referral:	
Referral agency:	
Referrer (Name & Job Title):	
Referrer phone:	
Referrer email:	

Client Details

1. First name:			
2. Last name:			
3. Preferred name:			
4. Gender:			
5. Date of birth:		**6.** Age:	
7. Mobile Phone:			
8. Email:			
9. Pension/HCC Type			
10. Pension/HCC Type		**11.** Card No.	
12. Address 1:			
13. City/Suburb		**14.** Postcode:	
15. Medicare Number		**16.** Expiry Date	
17. Emergency Name		**18.** Relationship	
19. Mobile Phone			
20. Do you identify as Aboriginal or Torres Strait Islander?	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither		
21. Country of birth:			
22. Language spoken at home:			
23. What is your primary reason for seeing the doctor?			
24. What is your COVID-19 vaccination status?	☐ Received 1st dose ☐ Received 2nd dose ☐ Unvaccinated		
25. What type of Covid-19 Vaccination did you have?	☐ Comirnaty (Pfizer) ☐ Astra Zennica ☐ Other		

Medical History

1. Have you been hospitalised in the past 12 months?	☐ Yes ☐ No
2. If yes, are you able to provide a discharge summary (if yes, please attach)	☐ Yes ☐ No
3. Do you have any allergies?	☐ Yes ☐ No Details:
4. Do you have any diagnosed medical conditions?	☐ Yes ☐ No Details:
5. Are you currently taking any medications?	☐ Yes ☐ No Details:
6. Do you have a diagnosed disability or problems with mobility?	☐ Yes ☐ No Details:
7. Are you linked with the NDIS?	☐ Yes ☐ No
8. Have drugs or alcohol ever stopped you from living the life you would like to lead?	☐ Yes ☐ No Primary: Additional: Last time used: Amount used:
9. Do you currently smoke cigarettes?	☐ Yes ☐ No
10. When was the last time you saw a dentist?	
11. Do you have a history of mental health diagnosis?	☐ Yes ☐ No Details:

12. Do you require a NSW Housing Medical Assessment?	☐ Yes ☐ No Details:
13. Are you under guardianship?	☐ Yes ☐ No Details:
14. To the best of your knowledge do you have any cognitive challenges?	☐ Yes ☐ No Brief description
15. Do you have any reason to believe you might have an acquired brain injury (ABI)?	☐ Yes ☐ No Details:
16. Is there anything else you feel is relevant to your healthcare or that you would like the doctor to know?	☐ Yes ☐ No Details:

Initial Physical Health Assessment

Clients known physical problems:

1. Asthma or airway disease	☐ Yes	☐ No
2. Blood pressure	☐ Yes	☐ No
3. Blood disorder, including anaemia	☐ Yes	☐ No
4. Diabetes	☐ Yes	☐ No
5. Ears	☐ Yes	☐ No
6. Eyes	☐ Yes	☐ No
7. Feet	☐ Yes	☐ No
8. Heart	☐ Yes	☐ No
9. Hepatitis A, B or C	☐ Yes	☐ No
10. Infection	☐ Yes	☐ No
11. Kidney or Urinary Tract	☐ Yes	☐ No
12. Living with HIV	☐ Yes	☐ No
13. Mouth	☐ Yes	☐ No
14. Musculo-skeletal (Knees, hips, back)	☐ Yes	☐ No
15. Skin – e.g. rashes	☐ Yes	☐ No
16. Stomach or Bowel	☐ Yes	☐ No
17. Teeth	☐ Yes	☐ No
18. Wounds	☐ Yes	☐ No
19. Other		

Support providers and exchange of information

1. Are you currently being supported by another agency?	☐ Yes ☐ No
2. If yes, please provide details:	Type of support provided: Agency: Contact name and title: Contact phone: Contact email:
3. Do you give The Haymarket General Practice permission to record your data in Medirecords? Medirecords is a database managed by the Haymarket General Practice, used for bookings and patient information management. Your details are kept confidential in line with our privacy policy, with anonymous information used for quality improvement and reporting to funders. If you would like to know more, please ask our Practice Manager for a copy of our privacy policy.	☐ Yes ☐ No
4. Do you give the Haymarket General Practice permission to contact other services to gather information about your circumstances? If you give us permission to exchange your information to another service, we will only provide the information required for the activities that you have requested and will not provide open access to your medical records.	☐ Yes ☐ No

I give permission to the Haymarket General Practice to exchange information with the following services. My permission is effective for the duration of my engagement with the practice. I understand that I can change myconsent at any time by letting my clinician or the practice manager know.

1.

2.

Acceptance

1. Client Name:	
2. Client Signature:	
3. Date:	
4. Case Manager Name:	
5. Case Manager Signature:	
6. Date:	

Office Use Only

Information added to Medirecords:	☐ Yes ☐ No