HEALTHY ME, HEALTHY COMMUNITY

REFERRAL FORM

WHO IS ELIGIBLE TO PARTICIPATE IN THE SERVICE? | People residing in the Port Macquarie-Hastings region, seeking increased community connections, and are aged 18 years or older.

The Healthy Me Healthy Community initiative is not intended to provided more intensive support, counselling or case management to participants. Please consider the level of support individuals require when referring participants.

PHONE: 1300 987 215 **FAX:** 1300 850 770 **EMAIL:** hmhc@feroscare.com.au **WEB:** feroscare.com.au/hmhcreferral

REFERRER DETAILS

This section must be completed.

Date: _____

Referring organisation: _____

Referrers name: _____

Referrer role: _____

Organisation address: _____

Contact phone: _____

Contact fax: _____

Contact email: _____

How did you hear of Healthy Me, Healthy Community program?

_____

CLIENT REGULAR GP DETAILS

If different to referrer details.

Regular GP:

◯ **Yes** ◯ **No** ◯ **Unsure**

Regular GP name: _____

Practice name: _____

Practice address: _____

_____

Contact phone: _____

GP visits:

◯ **Rarely** ◯ **Regularly** ◯ **Frequently** ◯ **Unsure**

CLIENT DETAILS *This section must be completed.*

First name: _____ Last name: _____

Gender: _____ Date of birth: _____

Home address: _____

Suburb: _____ Postcode: _____

Postal address if different to above: _____

_____

Phone: _____ Email: _____

Is client of Aboriginal or Torres Strait Islander Origin? ◯ **Aboriginal** ◯ **Torres Straight Islander** ◯ **Both** ◯ **NA**

Preferred language: _____ Is an interpreter required? ◯ **Yes** ◯ **No**

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CONSENT FOR REFERRAL *This section must be completed.*

Is the client aware of this referral and has consent been given?

◯ **Yes they are aware and given consent**

ADDITIONAL CLIENT INFORMATION *Please remember this is a NON clinical service.*

Does the client have a carer/support person:

◯ **Yes** ◯ **No** ◯ **Unsure**

If yes, please specify:_____

Any barriers to service:

◯ **Yes** ◯ **No** ◯ **Unsure**

If yes, please specify:_____

REASON FOR REFERRAL

Description of presenting or underlying issues:

Any significant history of relevance to this referral:

GP REPORTING *This section must be completed.*

Client progress and final reports to be sent to GP (patient consent required): ◯ **Yes** ◯ **No**

Please fax completed form to Feros Care 1300 850 770 or email hmhc@feroscare.com.au

To learn more please visit feroscare.com.au/hmhcreferral or scan the QR code.

HEALTHY NORTH COAST

phn NORTH COAST An Australian Government Initiative

feros care GROW BOLD

This program is funded by Healthy North Coast through the North Coast PHN program and is delivered by Feros Care.

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