|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Form** **Not-for-Profit Health and Human Services** PO Box 912, Fortitude Valley Q 4006 1800 996 246 [referrers@ozcare.org.au](mailto:referrers@ozcare.org.au) [www.ozcare.org.au](http://www.ozcare.org.au)/referrers | | | | | | | | | | | | | | | | | | | | | | |
| **Patient/Client Details** | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
| Given Name | | |  | | | | |  | | | | Surname | |  | | | | | | | |  |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
| Phone | | |  | | | | |  | | | | Email | |  | | | | | | | |  |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
| Gender | | |  | | | | |  | | | | Date of Birth | |  | | | | | | | |  |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
| Address | | |  | | | | | | | | | | | | | | | |  | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Contact Person/Carer Details** | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
| Name | | |  | | | | |  | | | | Relationship to Patient / Client | | | | |  | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | |
| Phone | | |  | | | | |  | | | |  | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Reason for Referral** | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
|  | | Residential Aged Care | | |  |  | Home Care - Aged | |  |  | | | Home Care – Disability | |  |  | | NDIS | | | | |
|  | | Respite Care | | |  |  | Day Respite Centre | |  |  | | | Dementia care / advice | |  |  | | Other | | | | |
|  | | Nursing | | |  |  | Allied Health | |  |  | | | Home Care Package | |  |  | | | | | | |
|  | | | |  | | | | | | |  | | |  | | | | | |  | | |
| **Referred by** | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
| Surgery / Hospital / Service Name | | | | | | | |  | | | | Phone | |  | | | | | | | |  |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | |  | | | | Email | |  | | | | | | | |  |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
| Provider Number | | |  | | | | |  | | | | Signature | |  | | | | | | | |  |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
| Contact Name | | |  | | | | |  | | | | Date | |  | | | | | | | |  |
| Note: it is the responsibility of the referring party to ensure consent has been given to share patient/client information with Ozcare | | | | | | | | | | | | | | | | | | | | | | |
| **Referral Notes** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |  | |
| **GP Health Summary Attached** | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
|  | | Yes | | |  |  | No | |  |  | | | Not applicable | |  | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | |  |
| **Fax to 3028 9630 or email to** [**referrers@ozcare.org.au**](mailto:referrers@ozcare.org.au)  **Call us on our priority referrer line: 1800 996 246 or visit** [**www.ozcare.org.au**](http://www.ozcare.org.au)**/referrers** | | | | | | | | | | | | | | | | | | | | | | |