BlueCare
Live life your way

CLIENT IDENTIFICATION LABEL
Last Name: _____
First Name: _____
Address: _____
Date of Birth: _____

REFERRAL FORM

Is this Referral urgent? Y N *(Must be clear rationale for "urgent referral" outlined in "Reason for Referral" section on next page.)*	Client/carer is aware of this referral Y N
Referral for (services required):	
Date of hospital discharge:	Date requested to commence:

Client Details

Mr/Mrs/Ms/Miss/Other:	Last name:	First name/s:	
DOB:	Gender:	Marital status:	Country of Birth:
Address:			
Phone No: (no spaces):	Mobile phone: (no spaces):	Email:	
Preferred Language: Interpreter needed: ❑ Y ❑ N	**Aboriginal / Torres Strait Islander status**: ❑ N/A ❑ Aboriginal only ❑ Torres Strait Islander only ❑ Both Aboriginal & Torres Strait Islander		

Additional Contact/Carer

Mr/Mrs/Ms/Miss/Other:	Last name:	First name/s:
Address:		
Phone No: (no spaces):	Mobile phone: (no spaces):	Email:
Relationship to client:		

Referral Source/Agency

Agency/service:	Contact person:	
Phone No: (no spaces):	Mobile Phone: (no spaces):	Email:

General Practitioner

Name and Provider number:		
Address:		
Phone No: (no spaces):	Mobile phone: (no spaces):	Email:

Funding *(please circle OR enter :Yes" into box below. To provide more details, enter onto Page 2 if needed)*

CHSP/QCSS *(NDIS status required for clients under 65yo)*	DVA CN	Post Acute funded *(scripting needed)*	Palliative Care Prog *(scripting)*	Palliative Care Prog R & R	Brokered *(Name of funding provider required)*	HCP	Other/Unknown

Signature:	Name:
Designation:	Date:
Are there any attachments? ❑ Y ❑ N (See P2 for details)	No of pages being sent (including Pages 1 & 2 of this form)

REFERRAL FORM

CT02

REFERRAL FORM

CLIENT IDENTIFICATION LABEL

Last Name: _____

First Name: _____

Address: _____

Date of Birth: _____

Reason for referral/further information

Provide detailed description of reason for referral / urgency

Other agencies involved in care/case management (provider and service):

Are there any attachments? ❑Y ❑ N

❑ Other referral/s ❑ Discharge Summary

❑ Medication Chart ❑ Prognosis confirmation letter

❑ Other (specify) _____

No of pages being sent (including Pages 1 & 2 of this form)

CT02