TOWNSVILLE

F: (07) 4421 7455
P: (07) 4722 8766

OFFICE HOURS Monday to Friday 8.30am – 4.30pm

Referral Form
Allied Health Services

If you consider this referral a high priority please call our office after faxing the referral

Eligibility

This person resides in a Rural Community Yes ☐ No ☐

Townsville residents with current Enhanced Primary Care (EPC) referral will be bulk billed, private fees apply if the person does not have EPC referral

Persons Details

First Name		Surname	
DOB		Gender	
Address			Postcode
Phone (work)	Phone (home)	Mobile	
Indigenous Status		Interpreter Required	Yes ☐ No ☐
Medicare Card #	Ref # Expiry	Health Care Card #	Expiry

Applicable Private Health Insurance? Yes ☐ No ☐

Contacts (Complete relevant field/s)

Can we contact these people if we are unable to contact the referred person to schedule an appointment Yes ☐ No ☐

Next of Kin/ Emergency Contact:

Name	Phone	
Address		Postcode
Relationship to person:		

Carer Details: (if applicable)

Name	Phone

Referrer Details (if applicable)

Name		
Organisation		
Address		Postcode
Fax	Provider Number	

Referral Information

Reason for Referral
Diagnosis
Allergies
Current Medications (Please attach medications summary)
Relevant medical history/conditions (Please attach health summary)

Please indicate Allied Health Discipline and preferred site for service delivery

Dietitian	Occupational Therapist	Exercise Physiologist	Diabetes Educator	Podiatrist	Group Lifestyle Modification Program
☐ Ayr		☐ Ayr	☐ Ayr		☐ Ayr
☐ Bowen		☐ Bowen	☐ Bowen		☐ Bowen
☐ Cannonvale		☐ Cannonvale			☐ Cannonvale
☐ Cardwell		☐ Cardwell	☐ Cardwell		☐ Cardwell
☐ Charters Towers		☐ Charters Towers	☐ Charters Towers		☐ Charters Towers
☐ Clermont			☐ Clermont		
☐ Collinsville			☐ Collinsville		
☐ Dysart			☐ Dysart		
			☐ Home Hill		
☐ Hughenden	☐ Hughenden	☐ Hughenden	☐ Hughenden	☐ Hughenden	☐ Hughenden
☐ Ingham		☐ Ingham	☐ Ingham		☐ Ingham
☐ Proserpine		☐ Proserpine			☐ Proserpine
☐ Moranbah			☐ Moranbah		
☐ Middlemount			☐ Middlemount		
☐ Richmond	☐ Richmond	☐ Richmond	☐ Richmond	☐ Richmond	☐ Richmond
☐ Sarina					
☐ Townsville		☐ Townsville	☐ Townsville		☐ Townsville
☐ Other		☐ Other	☐ Other		☐ Other

Is the person being referred under Chronic Disease Management (formerly EPC)? Yes ☐ No ☐

If YES please attach Team Care Arrangement (TCA)

Consent to referral:
I have discussed this referral with the person and/or their guardian and am satisfied that the person and/or their guardian understands and is able to provide informed consent to this referral

Referrer's signature: _____

Referral Date:

Please attach Medication Summary, Health Summary and/or TCA

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