

Referral Form Indigenous Outreach Worker

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

Eligibility

This practice participates in the Practice Incentive Program - Indigenous Health Incentive (PIP-IHI) Yes ☐ No ☐

This patient is PIP-IHI registered Yes ☐ No ☐

This patient has or is willing to have an Indigenous health check Yes (please attach copy) ☐ No ☐

Persons Details

First Name		Surname	
DOB		Gender	
Address			Postcode
Phone (work)	Phone (home)	Mobile	
Indigenous Status		Interpreter Required	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicare Card #	Ref #	Expiry	Health Care Card #
Applicable Private Health Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>		Expiry	

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
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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 select the service/s required

- ☐ Transport (health related only - e.g. health appointment, blood test)
- ☐ Collect Prescribed medications
- ☐ Support during appointment consultation/s
- ☐ Assistance filling out health related forms

Consent to referral:

My GP has discussed the IOW Program Brochure with me. I understand what I have been told, any questions I had about the program been satisfactorily answered and I now want to participate

- I understand that my participation is voluntary and that I have the right to withdraw from the program at any time
- I understand that statistical information (that will not identify me) will be collected and used to see how well the program is working and help improve services for Aboriginal and Torres Strait Islander people.

Referred person/ Carer name	
Signature:	

I have discussed the proposed referral to the IOW Program 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 copy of current ATSI Health Check (MBS 715)

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