**REFERRAL FORM – IUIH CONNECT**

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| **REFERRAL DETAILS** | | | | | | | | |
| Royal Brisbane & Women’s Hospital   The Prince Charles Hospital   Caboolture Base Hospital   Redcliffe Hospital   Kilcoy Base Hospital   Community Health  | | | Princess Alexandra Hospital   Redland Hospital   Logan Hospital   QEII Hospital   LCCH   Mater HHS  | | | | | |
| Primary Health Network  | | |
| *GP or other*  | | | | | | | | |
| Date: | Name of person referring: | | Department: | | | | | Contact Phone: |
| **PATIENT INFORMATION URN (if known):** | | | | | | | | |
| GIVEN NAME | |  | | | SURNAME |  | | |
| GENDER | |  Male  Female | | | D.O.B. |  | | |
| ADDRESS | |  | | | | | | |
| PHONE 1 | |  | | | PHONE 2 | |  | |
| ALTERNATE CONTACT: | |  | | | RELATIONSHIP TO PATIENT | |  | |
| PHONE 1 | |  | | | PHONE 2 | |  | |
| **ABORIGINAL AND TORRES STRAIT ISLANDER STATUS**   ABORIGINAL  BOTH   TORRES STRAIT ISLANDER  NEITHER | | | | | FIRST LANGUAGE | |  | |
| INTERPRETER NEEDED | |  NO  YES | |
| **HAS THE PATIENT CONSENTED TO THIS REFERRAL?  YES  NO**  Consent given to contact:   PATIENT  ALTERNATE CONTACT PERSON   MEDICAL PROFESSIONALS INVOLVED IN PATIENTS CARE | | | | | | | | |
| **REASON FOR REFERRAL** | | | | | | | | |
|  Care coordination   Linkage to GP service   Medical Aids | | | |  Transport assistance   CTG registration/prescriptions required   Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **IS THE PATIENT CURRENTLY IN HOSPITAL?  NO  YES - expected discharge date:** | | | | | | | | |
| **DOES THE PATIENT HAVE ANY APPOINTMENTS PENDING?** ** NO  YES**  **Please provide details:** | | | | | | | | |
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