IUIH Connect Plus | Client Referral Form

Call 1800 254 354
(7am to 7pm, 7 days a week)

Client Details					
Name					
DOB		Age		Gender	
Address					
Phone		Alternate contact			
Client identifies as	○ Aboriginal	○ Torres Strait Islander	○ Aboriginal & Torres Strait Islander		○ Neither
Referral date			Hospital URN		

Does the patient have any COVID-19 symptoms or have they been in contact with anyone who has COVID-19?	○ Yes	○ No
If yes, have they been tested for COVID-19 and were the results positive? Please list details		
Does the patient have a regular GP practice?	○ Yes	○ No
If yes, please provide GP practice details		
Is the patient currently in hospital?	○ Yes Expected discharge date:_________	○ No

Has the patient consented to this referral? ○ Yes ○ No

Patient has given consent to contact:
○ Patient ○ Alternate contact person ○ Medical professionals involved in patient's care

Referral needs:	
○ GP Support ○ Medical Aids ○ Cultural Support ○ Health Care Coordination	○ Transport Support ○ Allied Health ○ Social Health Support ○ Other…………………………………..

Attach supporting letters/documents and please provide details:

Referrer Details			
Name		Phone	
Organisation		Job title / Department	

Note: Contact cannot be made with patient until referral and consent is completed

Send referral via:
FAX: 3205 8666 EMAIL: iuihconnect@iuih.org.au

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