

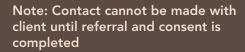
## **Client Referral Form**

Call 1800 254 354 (7am to 8pm, 7 days a week)

Is this a referral for a Mobility Aid prescription? If so, If so, please complete, the Mobility Aid Prescription referral form <u>here</u>

			tne iviobility Ala Prescription	reterral torm <b>nei</b>	
Client Deta	ails		,		
Name					
DOB		Age			
Gender/sex	Male	Female	others please specify		
Address					
Phone		Alternate Contact			
Client identif	fies as				
Aboriginal	Torres Strait Islander	Aboriginal & Torres Strait Isl	ander Neither   family of		
Secondary C	Client Details				
Parent/guard		n:			
Phone numb		Relationship to clie	nt		
Name	ontact (if different from	above):			
Phone number		Relationship to clie	Relationship to client		
Are there chi	ild safety or youth justic	· · · · · · · · · · · · · · · · · · ·	No	•	
Referral date		Hospital URN			
Medicare Number		Medicare Index	Medicare expi	ry	
Is the client currently in hospital?		Yes	No		
Expected discharge Provide details if th	e date: ney are under the care of any Specia	ltv teams			
Has the client consented to this referral?  Please note, if you answer 'no' Mob Link will not be able to contact		rral? Yes	No		
Has the clien	t consented to Mob Lin	k accessing IUIH medical reco	ords if available? Yes	No	
Reason for re Note: Please attach	eferral – please provide any supporting documents (ie Disc	a detailed explanation of rea harge summary, OT report)	son for referral		
Referrer Det	ails (To be contacted regarding	referral)			
Name		Phone	Phone		
Email Organisations					

Email form



**Position** 

Send referral via: FAX: 07 3205 8666

Department

