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 **here***

Client Details

Name

DOB **Age**

Gender/sex ☐ Male ☐ Female ☐ others please specify

Address

Phone **Alternate Contact**

Client identifies as

Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Neither | family of

Secondary Client Details

If client is under 18 or has a guardian:

Parent/guardian name

Phone number **Relationship to client**

Emergency contact (if different from above):

Name

Phone number **Relationship to client**

Are there child safety or youth justice orders? ☐ Yes ☐ No

If yes, please provide Authority to Care.

Referral date **Hospital URN**

Medicare Number **Medicare Index** **Medicare expiry**

Is the client currently in hospital? ☐ Yes ☐ No

Expected discharge date:

Provide details if they are under the care of any Specialty teams

Has the client consented to this referral? ☐ Yes ☐ No

Please note, if you answer 'no' Mob Link will not be able to contact the client.

Has the client consented to Mob Link accessing IUIH medical records if available? ☐ Yes ☐ No

Reason for referral – please provide a detailed explanation of reason for referral

Note: Please attach any supporting documents (ie Discharge summary, OT report)

Referrer Details *(To be contacted regarding referral)*

Name **Phone**

Email **Organisations**

Position **Department**

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

Email form

Send referral via:
FAX: 07 3205 8666

EMAIL: moblink@iuih.org.au