

**For Staff Use Only**

Unit Record Number: Click or tap here to enter text.

Surname: Click or tap here to enter text.

Given Name: Click or tap here to enter text.

Date of Birth:Click or tap here to enter text.**Affix Hospital I.D. Label If Available**

**Aboriginal Health Team**

**Service Referral**

**Client/Patient Name:** Click or tap here to enter text. **Telephone Number:** Click or tap here to enter text. **Address:** Click or tap here to enter text.

**Relevant Medical History:**

Click or tap here to enter text.

**Social (include living situation, significant others, services involved):**

Click or tap here to enter text.

**Next of Kin (provide up to 2 contacts):**

**Name Relationship Contact Details**

Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.

Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.

**Consent to Contact provided: Yes No**



**Reason for Referral (select from the following):**

**Discharge Planning  Health Screening/Health Condition Management**

**Cultural Support  Case Management/Advocacy (including medical transport)**

**Vulnerable person/Child  Counselling or Psychiatric Support**

**Social and Emotional Wellbeing  Drug and Alcohol Support**

**Access to Aboriginal Services  Cultural Support**

**Not Known/Client Request  HACC (domestic assistance/property maintenance**

**Social Groups and Community Activities**

**Not Known/Client Request**

**Additional Information:** Click or tap here to enter text.

**Referee Name:** Click or tap here to enter text.

**Role/Organisation:** Click or tap here to enter text.

**Signature of Referrer: ............................................ Phone:** Click or tap here to enter text.

**Date: .......... / .......... / ……….**

**Email to** [**AHTIntake@easternhealth.org.au**](mailto:AHTIntake@easternhealth.org.au) **Ph: (03) 5957 1100**