NSW GOVERNMENT Health
Western Sydney
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B.	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

WESTERN SYDNEY COMMUNITY HEALTH

REFERRAL FORM CHRONIC AND COMPLEX CARE

Referral Guidelines

1. Please complete all sections of this form and return to Central Referral Service via email to **WSLHD-CommunityHealth-ReferralService@health.nsw.gov.au**
2. Alternatively, referrals can be faxed to **9881 7789**.
3. Sections marked with an asterisk (*) are mandatory fields.
4. For enquiries, please phone **1800 600 681**.
5. **Community Health does not accept third party or workers compensation claim referrals**
6. For Clients over 65 years and over 50 years for Aboriginal/Torres Strait Islander clients please refer directly to My Aged Care: In My Aged Care this service provider is named **Allied Health & Community Nursing & Social Support Group WSLHD** https://www.myagedcare.gov.au/referral-form

Client Information

Client Name*:		
Address*:		
Suburb*:		Postcode*:
Medicare No.*:	Date of Birth*:	Sex*: ☐ Male ☐ Female
Home Phone*:	Mobile Phone:	
Email:		
Has the client consented to this referral*: ☐ Yes ☐ No		
Is the client Aboriginal or Torres Strait Islander*?	☐ No ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both Aboriginal and Torres Strait Islander ☐ Declined to respond ☐ Unknown	

My Aged Care

If client is 65 or over (50 or over if Aboriginal and/or Torres Strait Islander) a MAC referral is mandatory and a reference number must be provided - with the exclusion of Social Work*

MAC Reference Number:

Reason for Referral

Referral Type:	☐ Nursing	☐ Allied Health	☐ Aged Day Service
	☐ Wound care ☐ Supportive Care ☐ Continence ☐ Medications ☐ Chronic Disease Management ☐ Dementia Care ☐ Palliative Care NP - RACF	☐ Occupational Therapy ☐ Physiotherapy ☐ Podiatry ☐ Dietetics ☐ Social Work ☐ Speech Pathology	☐ Aged Day Service
Description of presenting issue and or treatment requested (must be completed) *Limited space to 5 text lines*			

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

191020

REFERRAL FORM CHRONIC AND COMPLEX CARE WSHR-0219

NSW GOVERNMENT | Health
Western Sydney
Local Health District

Facility:

WESTERN SYDNEY COMMUNITY HEALTH

REFERRAL FORM
CHRONIC AND COMPLEX CARE

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B.	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Service requested to commence	Date:
Country of Birth*:	
Interpreter required*: ☐ Yes ☐ No	Preferred Language*:

Living Arrangements

Type of Accommodation: Click arrow to select OR fill "Other" field Other:

Does the client live alone: ☐ Yes ☐ No

Carer Details

Does the client have a carer*? ☐ Yes ☐ No

If yes, who is their carer? (Full Name)

Address of Carer:

Carer's Contact Phone Number: Carer's Residency Status: ☐ Resident ☐ Non Resident

Date of Birth: Relationship:

Language spoken: Interpreter required? ☐ Yes ☐ No

Does Carer / Contact person need to be present at assessment? ☐ Yes ☐ No

Is the carer the person to contact for the client? ☐ Yes ☐ No

If no, who is the person to contact	Full Name: Address: Phone:

Care responsibilities

Is the client a carer? ☐ Yes ☐ No

If yes, who do they care for? (Full name)

Address (of person being cared for)

Their Date of Birth: Relationship:

Contact Phone Number: Residency Status: ☐ Resident ☐ Non Resident

Language spoken: Interpreter required? ☐ Yes ☐ No

GP Details

Name: Telephone:

Fax: Email:

Practice Name and Address:

Referrer Details *

Referral Date:	Referrer Name:
Referrer Phone:	Referrer Organisation: (if a hospital please state ward: _____)
Referrer Email:	

OFFICE USE ONLY:

Date received:	Date reviewed:
Actioned By:	

NO WRITING

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING