

Primary Health Care Referral Form

Email: referrals@rfdstas.org.au
Phone: (03) 6779 1483

Refer to RFDS Tasmania for:

- Physical Health North (cardiovascular, COPD, dementia, diagnosed mental health)
- Adult Mental Health

- Physical Health South (cardiovascular, COPD, musculoskeletal)
- Youth Mental Health

Area of support:	☐ Adult Mental Health ☐ COPD ☐ Diagnosed Mental He	☐ Dementia	l Health □ Cardiovascular Disease □ Musculoskeletal Disorder ealth North)	
Patient details:				
Title:	Given name:			
Surname:			Date of birth:	
Address:				
			Postcode:	
Phone: <u>(Home)</u>			(Mobile)	
Email:			☐ Tick here if patient is referring self	
Preferred contact meth	nod: 🗆 Email	☐ Home Phone	☐ Mobile Phone	
☐ Neither Aboriginal or	es Strait Islander □ Ab Torres Strait Islander ed: □ Yes □ No	☐ Rather not sa		_
Gender:				
Medicare Number:		IRN:	Expiry:	
Is this person able to co Are there any current of Please provide the deta Name:	ection only when referring onsent as a mature minor sustody or parenting orderils of a parent or guardia	r? ers in place? an who gives co	☐ Yes ☐ No ☐ Yes ☐ No	
			nship to patient:	

Please turn over and complete other side



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Are there any special considerations that RFDS Tasmania needs to be aware of for the patient's safety and the safety
of the workers?
If yes, please provide details below:
Are there any current Family Violence Orders in place? ☐ Yes ☐ No
Is there previous or current contact with Stronger Families Safe Kids? \Box Yes \Box No
Reason for Referral:
Referrer details: (to be completed by person referring on behalf of the patient)
Referrer name: Provider number (if relevant):
Organisation or role if relevant:
Relationship to patient:
Phone number:
Email address:
Would the referrer prefer to be contacted by an RFDS Tasmania representative to discuss any other details before initial contact with the patient? \Box Yes \Box No
Has the patient provided consent for this referral? \Box Yes \Box No
Does the patient consent to an RFDS Tasmania representative contacting themselves to discuss this referral?
□ Yes □ No
Has a health summary been attached? ☐ Yes ☐ No ☐ Not applicable
If no, does the patient consent to RFDS Tasmania to contact their GP for a health summary? \Box Yes \Box No Please note: all physical health participants require a health summary prior to commencement of program
Usual GP / GP Practice:
Patient signature for release of health summary: Date: