

Allied Health and Social Support Referral Form



Client Details				
Name:		UR:	DOB:	
			Gender:	
Preferred Name and/or pronouns:				
Residential Address:				
Postal Address:				
Email:				
Phone:		Mobile:		
Appointment reminder preference:		☐ SMS ☐ Phone		
Medicare No:		Ref No:	Expiry Date:	
Aboriginal or Torres Strait Islander:		Please choose		
GP / Medical Centre:				

Alternate Contact	
☐ Parent	Name:
☐ Carer	Contact Number:
☐ Emergency Contact	Relationship to client:

Funding Body			
Concession:	CRN:	EXP Date:	
☐ Health Care Card		☐ Pension Concession card	
☐ Other Centrelink payment:			
DVA:	☐ Gold Card ☐ White Card	DVA No:	
My Aged Care: Clients over 65 years or 50 years for Aboriginal / Torres Strait Islander			
Are you registered: ☐ Yes ☐ No		My Aged Care No: AC.	
Home Care / Support at Home Package: Choose SAH Level			
Provider/Care Partner:			
GP Chronic Condition Management Plan (CCMP):			
Transport Accident Commission (TAC) Claim No:		Date of Accident:	
Work Cover Claim No:		Date of Accident:	
Private Health Insurance:	☐ Hospital ☐ Extras	Membership No:	
NDIS Number:		NDIS Plan dates:	Start: End:
NDIS Plan Manager:		Plan Manager email:	
NDIS Support Coordinator:		Contact details:	

Allied Health and Social Support Referral Form



Demographic Details: GLCH receives some subsidised funding for client appointments and is required to report on the following to the Department of Health:

Country of Birth			
Preferred Language		Language spoken at home	
Living Arrangement	Living Arrangement - choose an item		
LGBTQI+	☐ Does Identify	☐ Does Not Identify	☐ Not stated
Sex at birth	☐ Female	☐ Male	☐ Not stated
Are you a refugee?	☐ Yes	☐ No	

Referral Details:

Referral for:	☐ Dietetics*	☐ Hand Therapy*	☐ Podiatry*
Please complete sections on pages 3-4	☐ Exercise Physiology	☐ Physiotherapy*	☐ Social Support
	☐ Occupational Therapy*	☐ AlertABLE Clinic	☐ AdaptABLE Clinic
What are your main concerns:			
Do you have a new or relevant diagnosis? ☐ New diagnosis ☐ Existing (6 months +)			
Have you had any falls, near misses or lost confidence in your ability to walk?			
☐ Has the distance you are able to comfortably walk, reduced?			
☐ Near miss (where you have been able to stop yourself falling)			
☐ 1 fall in the last 3 months			
☐ 2 or more falls in the last 3 months			
Has a referral been sent to us on your behalf? ☐ Yes ☐ No			
Referred by:		Approx Date sent:	
Have you had surgery or attended hospital within the last 6 weeks? ☐ Yes ☐ No			
Reason for admittance:			
Hospital:		Discharge Date:	

Consent:

☐ I give consent for this referral to GLCH Allied Health and/or Social Support Team.	
☐ I give consent to share relevant information with the professionals/services involved in clients care needs.	
☐ I give consent for the use of de identified data for reporting purposes (we are required to report certain demographic information to the Department of Health on clients receiving subsidised funding for appointments).	
☐ I give consent for the use of de identified data for research and evaluation projects (this allows GLCH to conduct our own research & to evaluate how we can improve services).	
Signature:	Parent/Guardian Name:
Verbal consent provided: ☐ Yes ☐ No	

Allied Health and Social Support Referral Form



Please complete all below relevant sections based on the referral service/s required.

Physiotherapy / Exercise Physiology / Hand Therapy

How long have you had this injury/problem?

Can you move the affected part? Yes ☐ No ☐

If not, has this been for: Less than 6 Weeks ☐ 6 Weeks Plus ☐

Does this injury/problem interfere with your:

Sleep? Yes ☐ No ☐ Daily activities? Yes ☐ No ☐

Job/Work? Yes ☐ No ☐ Mobility/Movement? Yes ☐ No ☐

Do you experience dizziness or vertigo? (Neuro Physio only) Yes ☐ No ☐

Do you require a brace or splint for your injury (Hand Therapy only) Yes ☐ No ☐

Have you had a significant change in function? (ie the ability to walk, transfer from sit to stand, pain, new sensation changes, reduced or loss of movement)

Additional information:

Occupational Therapy

Do you have a pressure injury (a sore that requires cream/wound treatment obtained from sitting or laying down)? ☐ Yes ☐ No

If yes: Have you received or currently receiving treatment by a nurse or doctor?

☐ Yes ☐ No

Location of the pressure injury:

How long have you had your pressure injury:

Do you currently receive palliative care services or have a condition which is considered palliative? ☐ Yes ☐ No

Do you use a mobility aid/s?

☐ Walking stick ☐ Walker ☐ Wheelchair ☐ Mobility scooter

Do you have someone caring for you who is finding it harder? ☐ Yes ☐ No

Have you had any falls in the last 3 months ☐ Yes ☐ No If yes, how many?

Additional information:

Podiatry

Are you Diabetic? Yes ☐ No ☐

Do you have a wound on your foot that is not healing? ☐ Yes ☐ No

If yes: Are you receiving treatment by a nurse or doctor? ☐ Yes ☐ No

Do you think you have an infection (area is hot, swollen and/or discharging) in your foot?

☐ Yes ☐ No If yes: We recommend you see your GP if you have not already done so.

Do you have a history of foot ulcers or lower limb amputation? ☐ Yes ☐ No

Do you have chronic kidney disease? ☐ Yes ☐ No

Allied Health and Social Support Referral Form



Dietetics	
Are you experiencing unintentional weight loss?	☐ Yes ☐ No
Do you have difficulty swallowing/chewing?	☐ Yes ☐
Do you have a chronic health condition? (Eg Irritable Bowel Syndrome, Polycystic Ovary Syndrome, Iron deficiency, Diabetes, Liver or Kidney disease)	
Are you pregnant?	☐ Yes ☐ No
Do you have any food allergies or intolerances? For paediatrics, this includes Cow's milk protein allergy	
Are you planning a lifestyle modification for disease prevention?	

Please return the completed referral form to our Service Access team via email to serviceaccess@glch.org.au or phone our Customer Support Officers on 03 5155 8370 for assistance.