

Referral Form



This form is for external referrals to RSL Care (ie: from GP, Hospital, HACC, etc), but can also be used for referrals with or by RSL Care.

Referrer Details		Urgent: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Contact Person	<input type="text"/>	Referral Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Phone	(<input type="text"/>) <input type="text"/>	Fax	(<input type="text"/>) <input type="text"/>
DVA Provider No.	<input type="text"/>		
Referral Source	<input type="text"/>		

Client Details			
Mr/Mrs/Ms (please circle) Other	<input type="text"/>	DOB	<input type="text"/> / <input type="text"/> / <input type="text"/>
Surname	<input type="text"/>	First Name	<input type="text"/>
Address	<input type="text"/>		
Suburb	<input type="text"/>	State	<input type="text"/>
		Postcode	<input type="text"/>
Phone (Home)	(<input type="text"/>) <input type="text"/>	Mobile	<input type="text"/>
Preferred Language	<input type="text"/>	Interpreter Required:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pension Type and Number (if applicable)	<input type="text"/>		
DVA Card Number (if applicable)	<input type="text"/>	Client/Carer consent given for this referral:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Client Signature (if available)	<input type="text"/>		

Carer/Next of Kin Details			
Name of Carer/Next of Kin	<input type="text"/>		
Relationship to Client	<input type="text"/>		
	EPOA <input type="checkbox"/>	Guardianship <input type="checkbox"/>	
Phone (Home)	(<input type="text"/>) <input type="text"/>	Mobile	<input type="text"/>

GP/Hospital Details			
Name	<input type="text"/>		
Phone	(<input type="text"/>) <input type="text"/>	Provider No	<input type="text"/>
Hospital discharge date and time (if applicable)	<input type="text"/>		

Care Services	
HomeCare: <input type="checkbox"/>	Residential Care: Low <input type="checkbox"/> High <input type="checkbox"/> Special (Dementia) <input type="checkbox"/>
Reason for referral and relevant medical history: (Please attach relevant documentation if required)	
<input type="text"/>	

Fax this completed referral form and any additional information to 1300 792 129
For more information call 1300 076 566 or visit www.rslcare.com.au