|  |  |  |
| --- | --- | --- |
| DOB |    | PID Number |
| Gender |   |   |
| Title |   | Surname |   |
| Given Names |   |
| Address |   |
|  | *(Type or affix sticker)* |

**Email Referral:** **screferrals@silverchain.org.au** **Facsimile Referrals: 1300 601 788**

**Client fulfils criteria for Primary Care at Home Referral:**

[ ]  Yes [ ]  No Client aware and consented to referral

[ ]  Yes [ ]  No Chronic physical and/or mental health condition *(i.e. diabetes, depression, COPD)*

|  |  |
| --- | --- |
| If Yes, Details: |       |

[ ]  Yes [ ]  No Client needs support in finding and/or forming a lasting connection with a GP

|  |  |
| --- | --- |
| Client Name: |       |
| Client Date of Birth: |       |
| Client Address: |       |
| Client Contact Number: |       |
| Client Demographics: | Aboriginal: Yes[ ]  No [ ]  Torres Strait Islander: Yes[ ]  No [ ] Gender: [ ]  Male [ ]  Female [ ]  Transgender [ ]  Other |
| Referrer Name and Organisation: |       |
|       |
| Referrer phone and email: |       |
| Current GP details: |       |
| Additional Information:* Reason for referral
* Health information
* Living arrangements
* Existing supports in place
 |       |
| **Safety and Environmental Risk:** |
| When and where will this client be next seen? | Home [ ]  Clinic [ ]  Other [ ] Date:       |
| Do you have Case workers who visit this client alone? | Yes[ ]  No [ ]  N/A [ ]  |
| Are there any concerns in relation to the client’s behaviour, substance use or environment they may compromise the safety of our staff? | Yes[ ]  No [ ]  |
| If Yes, please provide further details:       |