**Email Referral:** [**screferrals@silverchain.org.au**](mailto: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: | | |