KYABRAM DISTRICT HEALTH SERVICE

Office Use Only:

UR No. _ _ _ _ _ _

KDHS Ver. 6 Oct 2020

COMMUNITY HEALTH SELF-REFERRAL FOR SERVICES

Your personal details:

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Mx ☐ Other:	
* D.O.B:	Gender:
* Given name:	
* Family name:	
* Street address:	
	Postcode:
* Contact phone number: Home	Mobile
* Do you hold a current Medicare card?	☐ Yes _ _ _ _ _ _ _ _ _ _ _ _ - _ Expiry date: _ _/_ _ ☐ No
* Do you hold a current ☐ Healthcare or ☐ Pension card?	☐ Yes _ _ _- _ _ _-_ _ _ _ ☐ No
Preferred medical practice:	
Preferred General Practitioner:	

Details marked with an asterisk (*) must to be completed

Please select what program/therapy:

Programs

☐ Asthma Education Program	☐ Cardiac Rehab Group	☐ Life! Program
☐ Men's Health Group	☐ Mums & Bubs Exercise Group	☐ Pulmonary Rehab Group
☐ QUIT Program	☐ Strength and Balance Group	☐ Tai Chi Group
☐ Yogatherapy		

For Social Work Services please complete CR014

Therapy

☐ Advance Care Planning	☐ Dietitian	☐ Diabetes Education
☐ Exercise Physiology	☐ Occupational Therapy	☐ Podiatry
☐ Speech Therapy	☐ Well Women's Clinic	☐ Women's Health & Continence Physiotherapy

Health Inquiry – Community Health Nurse

☐ CHNurse - Tongala	☐ CHNurse - Stanhope	**Please complete and sign second page**

COMMUNITY HEALTH SELF-REFERRAL FOR SERVICES CR/012

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COMMUNITY HEALTH
SELF-REFERRAL FOR SERVICES

What are your health concerns:
Please help us in helping you by giving us some details about your medical needs

☐ I currently have a NDIS package/in the process of creating an NDIS package

This form has been made for the community of Kyabram District Health Service for self-referring.
Clinicians and Nursing staff will need to complete a ConnectingCare referral or complete the following SCTT tools provided on the Health.Vic website (health.vic.gov.au).
Practitioners are encouraged to complete a detailed referral letter with client's details.

- Consumer Information
- Referral Cover Sheet & Acknowledgement
- Summary & Referral Information
- Consent to Share Information

Please sign and return this document to Kyabram District Health Service or email copy of this document completed to referrals@kyhealth.org.au

Signature		Date	