Primary Health Care Referral Form

Email: referrals@rfdstas.org.au
Phone: (03) 6779 1483
Fax: (03) 7073 2044

Refer to RFDS Tasmania for:

- Physical Health North (cardiovascular, COPD, dementia, diagnosed mental health)
- Adult Mental Health
- Physical Health South (cardiovascular, COPD, musculoskeletal)
- Youth Mental Health

Area of support: ☐ Adult Mental Health ☐ Youth Mental Health ☐ Cardiovascular Disease ☐ COPD ☐ Dementia ☐ Musculoskeletal Disorder ☐ Nicotine Management ☐ Diagnosed Mental Health (Physical Health North)

Patient details:

Title: _____ Given name: _____

Surname: _____ Date of birth: _____

Address: _____

Suburb: _____ Postcode: _____

Phone: (Home) _____ (Mobile) _____

Email: _____ ☐ Tick here if patient is referring self

Preferred contact method: ☐ Email ☐ Home Phone ☐ Mobile Phone

ATSI origin:
☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander
☐ Neither Aboriginal or Torres Strait Islander ☐ Rather not say
Is an interpreter required: ☐ Yes ☐ No Preferred language: _____

Gender: _____

Medicare Number: _____ IRN: _____ Expiry: _____

Participants under 18 years old:
Please complete this section only when referring children under 18 years of age.
Is this person able to consent as a mature minor? ☐ Yes ☐ No
Are there any current custody or parenting orders in place? ☐ Yes ☐ No
Please provide the details of a parent or guardian who gives consent for the referral.

Name: _____

Address: _____

Phone number: _____ Relationship to patient: _____

Please turn over and complete other side

Royal Flying Doctor Service
TASMANIA

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Are there any special considerations that RFDS Tasmania needs to be aware of for the patient's safety and the safety of the workers? ☐ Yes ☐ No
If yes, please provide details below:

Are there any current Family Violence Orders in place? ☐ Yes ☐ No

Is there previous or current contact with Stronger Families Safe Kids? ☐ Yes ☐ No

Reason for Referral:

Referrer details: (to be completed by person referring on behalf of the patient)

Referrer name: _____ Provider number (if relevant): _____

Organisation or role if relevant: _____

Relationship to patient:_____

Phone number: _____

Email address: _____

Would the referrer prefer to be contacted by an RFDS Tasmania representative to discuss any other details before initial contact with the patient? ☐ Yes ☐ No

Has the patient provided consent for this referral? ☐ Yes ☐ No

Does the patient consent to an RFDS Tasmania representative contacting themselves to discuss this referral?

☐ Yes ☐ No

Has a health summary been attached? ☐ Yes ☐ No ☐ Not applicable

If no, does the patient consent to RFDS Tasmania to contact their GP for a health summary? ☐ Yes ☐ No

Please note: all physical health participants require a health summary prior to commencement of program

Usual GP / GP Practice: _____

Patient signature for release of health summary: _____ Date: _____