REFERRAL TO MATER ALLIED HEALTH SERVICES

Unit Record No. ______
Surname ______
Given Names ______
DOB ______ Sex ______

AFFIX PATIENT IDENTIFICATION LABEL HERE

To ensure a timely appointment, complete all sections of this form. Incomplete forms will be returned for completion.

Residential address ......
Suburb ...... State ...... Postal code ......
Home phone no. ...... Mobile phone no. ......
Interpreter required: ☐ Yes ☐ No Language
Is the patient of Aboriginal or Torres Strait Islander origin: ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No ☐ Unknown
Medicare eligible: ☐ Yes ☐ No Medicare no. ...... Card reference no. ...... Expiry date ......
Private health insurance: ☐ Yes ☐ No E-mail address ......
Compensable status: ☐ 3rd Party ☐ Personal injury ☐ Workcover Qld ☐ DVA ☐ Other, specify ......

Referral details service required

☐ **Urgent referral**

☐ **Audiology**
☐ **Mater Aged Placement Services (MAPS)**
☐ **Nutrition and Dietetics**

Occupational Therapy:
☐ Adult Stress Management
☐ Adult Hands and Rheumatology
☐ Complex Medical and Development needs
☐ **Physiotherapy**

Speech Pathology:
☐ Adult and paediatric feeding and swallowing
☐ Adult Fluency

Podiatry:
☐ High Risk Foot Service

Reason for referral: (Include or attach any relevant supporting information to assist appropriate triage)
Provisional diagnosis/ Presenting condition: (Including date of diagnosis) ......

Relevant clinical history/ Examination ......

Other relevant information:
Developmental delay? ☐ Yes ☐ No
Physical impairment? ☐ Yes ☐ No
Intellectual impairment? ☐ Yes ☐ No

Approximate developmental age ......
Mobility assistance required? ☐ Yes ☐ No
Specify ......
Behaviour/ socialisation concerns (e.g. autism)

Relevant investigations (include syndromes suspected or under investigation) ......

Any other relevant information: (e.g. current court orders, cultural background information) ......

Referring clinician to complete all fields clearly

Date of referral ...... Provider number ......
Referring clinician name ......
Practice address ......
Phone number ...... E-mail address ......
Fax number ...... Referring clinician signature ......

Binding margin - do not write. Do not reproduce by photocopying.
All clinical form creation and amendments must be conducted through Health Informatics.

12/17
Ver. 5.00
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REFERRAL TO MATER ALLIED HEALTH SERVICES 100

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