



MATER REFUGEE COMPLEX CARE CLINIC (MRCCC) COMMUNITY PROVIDER REFERRAL

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. Return form via fax to Mater Health Services 07 3163 8548.

Patient details

Patient's first name _____
Patient's surname _____
Gender: [] Male [] Female
Date of birth _____ Age _____
Residential address _____
Suburb _____ State _____ Postal code _____
Home phone number _____ Mobile phone number _____
Country of birth _____ Date of arrival in Australia _____
Interpreter required? [] Yes [] No Language spoken _____
Ethnicity _____

Health insurance status

Asylum seeker: [] With Medicare [] Without Medicare [] With Status Resolution Support Service (SRSS) assist.
Medicare eligible? [] Yes [] No
Health Care card? [] Yes [] No
Medicare number _____ Health Care card number _____
Card reference number _____ Card reference number _____
Expiry date _____ Expiry date _____

Visa category

Residential status: [] Permanent resident [] Temporary visa holder [] Australian citizen [] Community detention
Time spent in detention _____ months _____ years

Community General Practitioner

Has the patient seen a community GP in the past 12 months? [] Yes [] No
GP name _____
Practice name _____
GP address _____
Suburb _____ State _____ Postal code _____
Phone number _____ Fax number _____

Consent

Does the client consent to being referred to MRCCC? [] Yes [] No
Please note:
Where the client is under 18 years of age consent must be obtained from the parent or guardian. The parent or guardian must also attend the appointments.
Is the client under 18 years of age? [] Yes [] No
Has parental/ guardian consent been obtained? [] Yes [] No



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MRCCC COMMUNITY PROVIDER REFERRAL 100



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Reason for referral

Main presenting concerns including physical, psychological, socio-cultural (Include or attach any relevant supporting information to assist appropriate prioritisation)

Multiple horizontal dotted lines for text entry.

GP preference: Male Female No preference

Referrer details

Form fields for Referrer details: Date of referral, Organisation, Name of referrer, Position/ Role, Signature, Organisation address, Suburb, State, Postal code, Phone number, Fax number, Email address.

Office use only

Form fields for Office use only: Date received, Category (1, 2, 3), Entered into RHC database, MRCCC referral meeting date, Accepted, date, Pending, specify reason, Date to be revised, Declined, specify reason, Date declined, UR number, Appointment letter sent to (Client, Referrer), Appointment booked for nurse health assessment, Date of appointment, Appointment booked with GP, Date of first appointment, Interpreter booked? (Yes, No).

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