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. Forms can be returned to Mater via email: mrccc@mater.org.au or fax: 07 3163 8548

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

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 ....
Email address ....
Country of birth .... Date of arrival in Australia ....
Interpreter required? ☐ Yes ☐ No Language spoken ....
Ethnicity ....

Health insurance status

Medicare eligible? ☐ Yes ☐ No
Medicare number ....
Card reference number ....
Expiry date ....

Health Care card? ☐ Yes ☐ No
Health Care card number ....
Card reference number ....
Expiry date ....

Visa category

☐ TPV ☐ SHEV ☐ Permanent resident ☐ Citizen ☐ Asylum seeker
Has the patient lodged a claim for protection? ☐ Yes ☐ No ☐ Bridging Visa ☐ Final departure ☐ No visa

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 16 years of age consent must be obtained from the parent or guardian.
Is the client under 16 years of age? ☐ Yes ☐ No
Has parental/guardian consent been obtained? ☐ Yes ☐ No
Next of kin name .... Date of birth ....
Next of kin contact number ....

MRCCC COMMUNITY PROVIDER REFERRAL

03/21
Ver. 4.00
F3278

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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) ....

GP preference: ☐ Male ☐ Female ☐ No preference

Referrer details

Date of referral .... Organisation ....

Name of referrer ....

Position/ Role .... Signature ....

Organisation address ....

Suburb .... State .... Postal code ....

Phone number .... Fax number ....

Email address ....

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