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| **Client details** |
| Name: Preferred Name:Date of birth:Email Address | Gender (self –identified):Phone No. (daytime):Phone No. (mobile): Home Address |
| **Referrer details (if applicable)**  |
| Date of Referral:Name:Job Title:Email Address: | Urgency:Practice name:Phone No (daytime) |
| **Health Information** |
| Current health concerns: Previous medical history:Current medications:  |

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| **Reason for referral** |
| What two main things do you wish to gain from Thrive rehab1.12.\* *Referrer please attach any assessment/ discharge summaries or intervention reports.* |
| **Important Contacts** |
| Emergency contact:Relationship:Case Manger:Allied Health:Regular GP:  | Mobile:Phone / email details: Phone / email details:Phone / email details:  |
| **Funding** |
| TAC Number: NDIS plan No: Plan Dates: / /2019 - / /202Please circle: Self-managed,  Plan managed   NDIS agency | NDIS Plan manager / Support coordinatorName:  Phone:Email: Organisation:  |
| **Consent and confidentiality** |
| Under the privacy act, we need your permission to discuss or access any details about you. We therefore ask referrers to discuss this referral with you and for you to sign your consent on this form with the knowledge that your private information will only be discussed with other health professionals involved in your care. If you are unable to sign at the time of referral this will be discussed at the time of the initial visit.*By signing below* **Choose most relevant response**…. (Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / Referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) *acknowledge that*;(Client’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) *understands the above information; consent to this referral and to sharing of health information with referrer.* Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name if not client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Thank you for taking the time to complete this form!*