Health
South Eastern Sydney
Local Health District

NSW GOVERNMENT

Facility: South East Aboriginal Health Care (SEAHC)

REFERRAL FOR CARE COORDINATION

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES010440

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

South East Aboriginal Health Care (SEAHC)

Referral for Care Coordination

for Aboriginal and Torres Strait Islander People

Fax No: 02 9540 8165

Note: This is a secure Fax Number

Date of Referral: _____

Patient Details

Name: _____

Date of Birth: _____

Address: _____

Phone Home: _____ Mobile: _____

Chronic Illness:

- ☐ Diabetes:
- ☐ Chronic Renal Disease:
- ☐ Cancer
- ☐ Cardiovascular Disease (E.g. Hypertension):
- ☐ Chronic Respiratory Disease (E.g. COPD, Asthma):
- ☐ Other: _____

Reason for Referral:

- ☐ Coordination of care
- ☐ Assistance with access to services
- ☐ Support with self-management
- ☐ Aboriginal Outreach Worker
- ☐ Other: _____

_____

Supporting Documents:

GPMP: ☐ attached ☐ to be completed

TCA: ☐ attached ☐ to be completed

Source of referral:

_____

Address: _____

_____

Phone No: _____

GP Name:

_____

GP Address: _____

_____

_____

REFERRAL FOR CARE COORDINATION

SES010.440

S0996 190717

NO WRITING