

Clinical Outreach Team Referral Form

Send completed form to email: SESLHD-HIVCommunityTeam@health.nsw.gov.au. For more information or help making a referral call the Clinical Outreach Team Intake on 0407 404 320.

Referral Details

Date of Referral: _____

Referrer Name: _____

Referrer Relationship:

Self Friend/Family/Carer Service Provider Other: _____

Referrer Phone: _____

Referrer Email: _____

Reason for Referral:

Client Information

First Name: _____ Family Name: _____

Preferred Name: _____

Date of Birth (dd/mm/yyyy): _____

Address: _____

Phone/Mobile Number: _____

Country of Birth: _____

Aboriginal and/or Torres Strait Islander: Aboriginal Torres Strait Islander Neither

Gender: _____

Language Spoken at Home: _____

Interpreter Needed: Yes No

Medicare Number: _____ No Medicare

Eligibility

Is the person living with HIV? Yes No*

Is the person living in the person living in the SESLHD Catchment: Yes No*

Is the person aware of referral? Yes No*

* Our team supports people living with HIV who live in SESLHD catchment and ideally they are aware of the referral. If unsure please contact our intake number to discuss the referral further.

Additional Information

HIV Management

Diagnosis Date: _____

Last Blood Test Date: _____ Viral Load: _____ CD4: _____

ART: _____

Treatment Provider: _____

Other Relevant History (Medical / Mental Health / AOD / Safety Concerns / Other Issues):