Health
South Eastern Sydney
Local Health District

NSW GOVERNMENT

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

HIV OUTREACH TEAM
CLIENT INTAKE AND REGISTRATION

Referral date: ____/____/____ **Gender:** ☐ M ☐ F ☐ Transgender ☐ Other

Priority Population group (please tick more than one, if known):

☐ Gay / MSM ☐ Heterosexual ☐ Sex Worker ☐ People who inject drugs ☐ CALD

Country of Birth ☐ Australia ☐ Other _____

Indigenous Status ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown

Preferred Language (or language at home) ☐ English ☐ Interpreter Need (specify language) _____

Contact details

Home: ( ) _____ Work: ( ) _____ Mobile: _____

Email: _____

Client Status

☐ New to Service ☐ Subsequent episode ☐ Previously seen by: _____

Is client aware of referral: ☐ Yes ☐ No

Referral Details

Referred by - Name/Organisation: _____

Phone / Mobile: _____

Reason for this referral / presenting problem:
(Please specify what role you would like our service to provide in assisting you with the client's support)

_____

_____

_____

_____

Medical / Mental Health / AOD history and other relevant problems or issues:

_____

_____

_____

_____

Safety Issues:

_____

_____

For office use only

Intake Officer: _____ Signature: _____ Designation: _____

Date: ____/____/____ Allocated to: _____

PLEASE FAX TO: (02) 9382 8658 HIV OUTREACH TEAM **ENQUIRIES:** (02) 9382 8666

NO WRITING

SES005108

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

HIV OUTREACH TEAM CLIENT INTAKE AND REGISTRATION SES005.108

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