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

REFERRAL – BULBUWIL ABORIGINAL HEALTHY-LIFESTYLE PROGRAM

SES010471

REFERRAL FOR HEALTH COACHING AND HEALTHY LIFESTYLE PROGRAMS

Bulbuwil is a free healthy-lifestyle program for Aboriginal and Torres Strait Islander people (aged 15yrs +) and their families who have or are at risk of a chronic health condition and reside within the Sutherland Shire and St George areas.

The program provides individual advice on minimising the impact of chronic conditions and healthy lifestyle group programs.

Hours of service Mon- Fri 8:00am – 4:30pm.
Enquiries: Call 02 9540 8181
Please return completed referral form to the Bulbuwil team
Email: seslhd-bulbuwil@health.nsw.gov.au OR Fax (02) 9540 8164

PROGRAM ELIGIBILITY CRITERIA:

☐ Client consented to the referral (This service is by voluntary engagement and requires consent)

Is the person of Aboriginal and/or Torres Strait Islander descent?

☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither

(If neither, are they a partner of an Aboriginal and/or Torres Strait Islander client?) ☐ Yes ☐ No

If so, Who?

Client Details

Given name:	Family name:
Date Of Birth:	MRN (if known):
Home address:	Home phone number:
	Mobile phone number:
Email address:	
Preferred language:	Interpreter required: ☐ Yes ☐ No

Is the client a carer? ☐ Yes ☐ No
Does the client have a carer? ☐ Yes ☐ No *(if yes, complete below)*

Carer name (if applicable):	Carer contact number:

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

REFERRAL – Bulbuwil Aboriginal Healthy-Lifestyle Program
SES010.471

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REFERRAL – BULBUWIL ABORIGINAL HEALTHY-LIFESTYLE PROGRAM

Reason For Referral/Health Goals (select relevant boxes):

Reason for referral

Services client wishes to access (please tick relevant box/es)

☐ Bulbuwil- Eye Clinic
☐ Bulbuwil-Cooking
☐ Bulbuwil-Dietetic
☐ Bulbuwil- NRT
☐ Bulbuwil-Gym (GP consent required)
☐ Bulbuwil -Water exercise (PM- working and/or studying-GP consent required)
☐ Bulbuwil- Walk (GP consent required)
☐ Bulbuwil-Water exercise (AM) (GP consent required)
☐ Bulbuwil- Other (i.e. health information (diabetes, cardiac, respiratory)

☐ Other:

Client health goal/s (Please describe):

Referral Source

☐ GP ☐ Self ☐ Family ☐ Friend ☐ Carer ☐ Service provider

Referrer Details

Given name:	Family name:
Contact number:	Referral Date:
Email address:	
Role:	

GP Details

GP name:	GP practice:
Phone number:	Fax number:
Email address:	

Any Other Services Accessed?

☐ NDIS ☐ My Aged Care ☐ Allied Health ☐ South East Aboriginal Health Care (SEAHC)

☐ Other (If other please state):

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BINDING MARGIN - NO WRITING

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NO WRITING