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

CLINIC REFERRED TO: ST GEORGE / SUTHERLAND SUPPORTIVE CARE CLINIC

SES010427

Dear Dr

Please accept this indefinite referral for the patient below

Date of Referral: / /

Location referred to: ☐ **St George** ☐ **Sutherland**

Referrer Details

Family name:	Signature: Print and Sign
Speciality:	Provider number:
Contact phone:	Contact Fax/Email:

Patient Details

Surname:	Given name:	Gender:	DOB: / /
Address:			
Home Phone:	Mobile:	Email:	
Medicare No:		Aboriginal and/or Torres strait Islander? ☐ Y ☐ N	
Country of Birth:	Preferred Language:	Interpreter? ☐ Y ☐ N	

Next of Kin/Carer

Name:	Contact number:
Is the patient aware of the referral? ☐ Y ☐ N	Is the carer aware of the referral? ☐ Y ☐ N

Service Providers

GP Name:	GP Phone:
Other specialists involved in patient care:	
Other community services involved? ☐ Y ☐ N Please specify:	NDIS: ☐ Y ☐ N

Clinical details

Life-limiting illness diagnosis:	**Other co-morbidities:**
☐ **Attached copy of medical history and recent specialist letters**	☐ **Attached copy of current medication list**

Reason For Referral:

Advanced Care Planning Completed: (Attach copy of any relevant documents)	☐ Y ☐ N
Any additional information:	

Multidisciplinary Team Needs? ☐ Y ☐ N

☐ Social Worker	☐ Psychologist
☐ Occupational Therapist	☐ Physiotherapist
☐ Dietitian	☐ Speech Pathologist
☐ Aboriginal Liaison Officer	☐ Pharmacist

If you would like to discuss the referral please contact the community supportive care services CNC for the St George and Sutherland area: (02) 9113 4182 (Monday to Friday 8am – 4:30pm)

Please send referral to: Email - SESLHD-StGeorgeSCS@health.nsw.gov.au

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

CLINIC REFERRED TO: ST GEORGE / SUTHERLAND SUPPORTIVE CARE CLINIC SES010.427

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