



Third Party Referral Form

Referring agency & individual details

Name of individual & agency:

Relationship to client:

Referrer address:

Referrer phone:

Referrer email:

Referral date:

Consent received from patient for this referral? yes no

Patient details

First name:

Surname:

Address:

Postcode:

Suburb:

Phone:

Email:

Interpreter required: yes no

Date of birth:

Preferred language:

Country of birth:

Gender: male female other

Ethnicity:

Year of arrival in Australia:

Visa status: Aust PR/citizen Temp protection

Medicare eligible: yes no Int student Temp migrant other

Medicare number:

Expiry:

Health Care/Pensioner Card Number:

Expiry:

Private Health Policy Number:

Expiry:

Patient usual GP name:

Clinic name:

Reason for changing GP:



Emergency Contact/Next of Kin name:

Contact number:

Relationship to client:

Client's preferred day or time for appointments:

Client's preferred gender of practitioner:

Case Manager/support worker's name:

Agency:

Ph:

Email:

Services of interest

- GP & medical
- Asylum Healthcare
- Mental health
- Allied Health: specify
- Acupuncture
- Massage
- Health education
- Group programs: specify
- Other: specify

Details of referral

Reason for referral & any relevant notes:

Please fax the completed form directly to World Wellness Group: (07) 3397 1358 or email to

admin@worldwellnessgroup.org.au

Thank you for your referral