

Referral Form Social Work Services for GP Practices

***Supports linkage and co-ordination of community psychosocial supports to compliment better patient outcomes.***

**Please read before completing:**

* This referral form can be completed by any member of GP Practice staff with consent of the patient.
* Referral form can be submitted in handwritten or typed format, scanned or MS Word Document/PDF formats.
* Provide attachments/supporting documentation as appropriate for any question and record ‘See Attachment’.
* Once completed please forward referral to[**referrals@ccnb.com.au**](mailto:referrals@ccnb.com.au)or fax: 02 9979 7611
* For further information please feel free to contact CCNB Health and Community Services Team 1300 002 262

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| **Inclusion Criteria** | Y/ N/ NK |
| The patient being referred consents to this referral being made |  |
| The patient being referred has been recently hospitalised and is at risk of being without support |  |
| The patient has chronic and/or complex health care conditions |  |
| The patient does not have a mental health diagnosis of an acute, persistent and/or severe nature. |  |
| The patient lives in Willoughby, Lane Cove, North Sydney, Manly, Warringah, Pittwater and Mosman |  |

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| **Referrers Details** | |
| **Name of Referrer:** | **Date of Referral:** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| **Email:** | **Landline**: |
| **GP Practice** | **Suburb** |
| **Best time and method to contact you if required?** | With patient consent would you like feedback on activity and progress?  How often?  What format/method is best? |
| **How did you find out about us?** |
| **Declaration**: The referrer agrees that all information included in this referral form is a full and accurate reflection of the support needs of the patient being referred based on your knowledge, experience and professional assessment of the individual and is necessary for CCNB to fulfil its duty of care to patients, staff and the community. | |

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| **Patient Details** | | | | | | | | |
| **Patient Name** |  | | | | **Gender** | |  | |
| **Medical Record No.** |  | | | | **Date of Birth** | |  | |
| **Address** |  | | | | **Suburb** | |  | |
| **Landline** |  | | | | **Mobile** | |  | |
| **What the best time to contact?** | | |  | | | | | |
| **How is it best to contact and communicate?** | | |  | | | | | |
| **Where’s the best place to meet?** | | |  | | | | | |
| **Does the patient have a substantive carer/family support?** Yes  No  Unknown   **Are they aware of this referral?** Yes  No  Unknown   **Can we contact them?** Yes  No   **Legal Guardian in place?** Yes  No   **Name and contact details:** | | | | | | | | |
| **Income source:** Working  NewStart  Aged  Disability Pension  No income  Not known  | | | | | | | | |
| **Culturally and Linguistically Diverse?** Yes  No NK   **Language(s):** | | | | **Interpreter Required**? Yes  No  | | | | |
| First Australian or Torres Strait Islander Yes No  NK  | | | | **LGBTI** Yes  No  Unknown  | | | | |
| **Family/Carer Details** | | | | | | | | **Y/ N/ NK** |
| Does the patient have family or carers? | | | | | | | |  |
| Is the family or carer aware of the referral to the Social Work Programme? | | | | | | | |  |
| Name and contact details: | | | | | | | | |
| Outline medical, health and social issues. | | | | | | | | |
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| Outline Other Co-existing issues (could include but is not limited to Drug and Alcohol/ Housing/Financial/Legal/Social and Vocational participation) the individual experiences. | | | | | | | | |
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| Are there any **individual or environment risks** we need to be aware of and assist in mitigating? | | | | | | | | |
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| Are there other services involved? | | | | | | | | |
| **Service Name:** | | **Type of Services Provide:** | | | | **Currently involved/history** | | |
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