



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____		M.O.
ADDRESS		
LOCATION/WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

COMMUNITY CARE INTAKE SERVICE REFERRAL

Services required: Appointment required within 24 hours? Yes No
 Date of referral to CCIS: Date 1st visit appointment:
 Allergies: Alerts:

All fields are mandatory. INCOMPLETE REFERRALS WILL NOT BE ACCEPTED.

Client Details

Medicare Number:
 Financial Class: Fund:

Next of Kin

Full name: Contact number:

Treatment Address

Street: Suburb: Postcode:
 Home phone: Mobile:
 Email:

Residential Address

As above Mobile:
 Street: Suburb: Postcode:
 Country of birth: Preferred language:
 Interpreter required? Yes No
 Reason for referral / treatment requested / wound treatment:

Diagnosis / history and current services:

Referrer Details *(Please note: if further information is required the CCIS Team will contact you)*

Referrer Name: Referring Service:
 Provider No: Phone: Fax:

GP Details

GP Name: GP Practice:
 Provider No: Phone: Fax:

PLEASE SEND REFERRAL WITH THE BELOW DOCUMENTS INCLUDING PATIENT DETAILS ON EACH PAGE

Community Nursing

- Wound chart
- Drain management and instruction form
- Medication chart
- VAC treatment and observation chart
- PICC / iVIEW line information
- GP Health Summary

Palliative Care

- PCOC (Peacock)
- GP Health Summary
- Letter re: diagnosis and treatment *(if not with referral of information referral)*

Allied Health

- GP Health Summary
- Latest Pathology Results

Aged Care

- GP Referral Letter (geriatrician only)
- Latest Pathology and Imaging Results

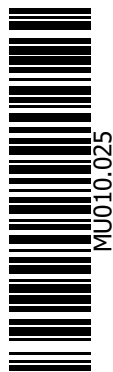
Secure Fax Number: 02 6933 9205

Telephone: 1800 654 324

Email: MLHD-CCIS@health.nsw.gov.au

NO WRITING

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MU010.025

Holes Punched as per AS2828.1:2012
 BINDING MARGIN - NO WRITING

MU566475 CW17 112021

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