Health
Murrumbidgee
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. / /	M.O.
ADDRESS	
LOCATION/WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

COMMUNITY CARE INTAKE SERVICE REFERRAL

MU010.025

Services required: ..... Appointment required within 24 hours? ☐ Yes ☐ No

Date of referral to CCIS: ..... Date 1st visit appointment: .....

Allergies: ..... Alerts: .....

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	Palliative Care	Allied Health
☐ Wound chart	☐ PCOC (Peacock)	☐ GP Health Summary
☐ Drain management and instruction form	☐ GP Health Summary	☐ Latest Pathology Results
☐ Medication chart	☐ Letter re: diagnosis and treatment *(if not with referral of information referral)*	
☐ VAC treatment and observation chart		
☐ PICC / iVIEW line information		
☐ GP Health Summary		

Secure Fax Number: 02 6933 9205 **Telephone: 1800 654 324** **Email: MLHD-CCIS@health.nsw.gov.au**

NO WRITING

COMMUNITY CARE INTAKE SERVICE REFERRAL MU010.025