



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: .....

**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**

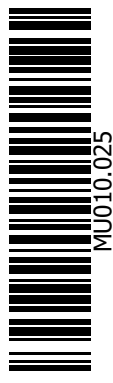
**Community Nursing**

**Palliative Care**

**Allied Health**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Wound chart                           | <input type="checkbox"/> PCOC (Peacock)  | <input type="checkbox"/> GP Health Summary        |
| <input type="checkbox"/> Drain management and instruction form | <input type="checkbox"/> GP Health Summary   | <input type="checkbox"/> Latest Pathology Results |
| <input type="checkbox"/> Medication chart                      | <input type="checkbox"/> Letter re: diagnosis and treatment<br><i>(if not with referral of information referral)</i> |   |
| <input type="checkbox"/> VAC treatment and observation chart   |  |   |
| <input type="checkbox"/> PICC / iVIEW line information         |  |   |
| <input type="checkbox"/> GP Health Summary                     |  |   |

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



MU010.025

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

MU566475 CW14042020

COMMUNITY CARE INTAKE SERVICE REFERRAL

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