

# Primary Care & Community Health Network

## Client Registration & Service Request Form

HOME First Phone: 1800 013 101      CONNECT First Phone: 1800 222 608  
 Fax: 47 59 8728      Fax: 47 32 9485

Has the client ever accessed/used Sydney West Area Health Service

Yes  No  Hospital  Community Health

Circle Current Service Pathway Requested below

CONNECT First	Health One	HOME First	Care Navigation	IVPRS	Youth Health
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Title	Surname	Alias/Previous Name	Given Names
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<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Indeterminate	Date of Birth	Country of birth	Overseas Status
		Cultural background	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>

<b>Address</b> _____ _____ _____ Postcode <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Telephone</b> Home: _____ Mobile: _____ Work: _____	<b>Marital Status</b> <input type="checkbox"/> Declined to respond <input type="checkbox"/> Divorced <input type="checkbox"/> Married or De facto <input type="checkbox"/> Never Married <input type="checkbox"/> Not Specified <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/> Widowed
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<b>Spoken Language</b>  <b>Needs Interpreter</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Indigenous status</b> (Tick one of the following) <input type="checkbox"/> Identifies as Aboriginal Origin <input type="checkbox"/> Identifies as Both A & TSI <input type="checkbox"/> Declined to respond <input type="checkbox"/> Neither A/TSI <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Unknown	<b>Religion (Specify)</b> _____ <input type="checkbox"/> Unknown
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**Medicare Card**  Yes  No      **Medicare Card No** \_\_\_\_\_ / \_\_\_\_  
**DVA Card**  Yes  No      **Colour** \_\_\_\_\_      **DVA Card No.** \_\_\_\_\_      **Exp Date** / /

**Person for Contact:** (For Children 0 – 18 yrs, please provide parent/guardian details)  
 Surname \_\_\_\_\_ Given Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_  
**Mothers full Name** (for children 0-18yrs) \_\_\_\_\_ Phone: \_\_\_\_\_  
 Mother's AUID (if known) \_\_\_\_\_

**Current GP/LMO** \_\_\_\_\_      **Phone:** \_\_\_\_\_      **FAX:** \_\_\_\_\_  
**Suburb** \_\_\_\_\_

**SWAHS Office Use Only:**      **AUID:** \_\_\_\_\_

**iPM Reg Date** \_\_\_\_\_      **Time** \_\_\_\_\_

<b>Intake taken by</b> _____	<b>Date</b> / / _____	<b>Signature</b> _____
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**Received Date of Referral** / /      **Time** \_\_\_\_\_      **CH Allocation List**

CONNECT First	Health One	HOME First	Care Navigation	IVPRS	Youth Health
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**Non Urgent**       **Urgent**       (Date required if urgent) \_\_\_\_\_

NAME:

AUID:

Referral Source GP client family service provider hospital other

Referral Method fax telephone email face to face other

Referrer Awareness of Service previous contact friend / family service provider other

Referrer Details Name \_\_\_\_\_ Position \_\_\_\_\_

Address \_\_\_\_\_ Suburb \_\_\_\_\_

Phone \_\_\_\_\_ Mobile \_\_\_\_\_ FAX \_\_\_\_\_

Organisation \_\_\_\_\_

Description of Presenting Issue / Problem:

Past Medical history / investigations:

Family History

Social History

Allergies:

Current medications:

Service Requested:

NOTE: Request for medication administration/wound management (requires GP/Medical orders)

Date Service Requested to commence / /

Client Living Arrangements: lives alone with family other

Carer Present: Yes No Relationship to Client \_\_\_\_\_

Carer Residency Status: Resident Non-resident

Does carer/contact person need to be present at assessment: Yes No

Safety Issues:

Falls Screen:

1. Have you had a fall in the last 12 months?	Yes	No	Unknown
2. Do you take 4 or more medications?	Yes	No	Unknown
3. Have you ever had a stroke or do you have Parkinson's disease?	Yes	No	Unknown
4. Do you have any problems with your balance?	Yes	No	Unknown
5. Do you need to use your arms to get up from a chair?	Yes	No	Unknown

If other agencies involved: Who? For what?

Other notes about action taken:

NOTE: all referrals are triaged &amp; prioritised according to need &amp; service availability