



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  
 Are you of Aboriginal and/or Torres Strait Islander Origin?  
 No  Yes *if yes* →  Aboriginal origin  Torres Strait Islander origin  Both  Declined to respond  Unknown  
 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**

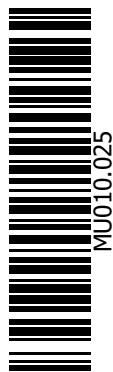
- GP Health Summary
- Latest Pathology Results

**Aged Care**

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

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 CW14122022

COMMUNITY CARE INTAKE SERVICE REFERRAL

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