**Referral form for the Refugee Health Nurse Program**

**Please complete as much of the information as known then email or fax to NSW RHS**

**Email to:** RHS.Referrals@sswahs.nsw.gov.au **Fax to: (02) 8778 0790**

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| **Client details** |
| Surname |  |
| First name |  |
| Other names |  |
| Date of birth |  |
| Country of birth |  |
| Gender | **MALE / FEMALE** |
| HEMS number (if known) |  |
| Medicare Number (include position number on card) |  |  |  |  |  |  |  |  |  |  |  |
| Health care Card Number |  |  |  |  |  |  |  |  |  |  |  |
| Number of adults in the family |  | Names of adultsother than client |  | **Note:** **Add each person’s details to page 3 of** **this form if you would like to refer them for an assessment** |
| Number of children in the family |  | Names of children other than client |  |
| **Language details** |
| Preferred language  |  |
| Other languages spoken |  |
| English language proficiency |  |
| Literacy in own language |  |
| Interpreter required | **YES / NO** |
| Interpreter needs (e.g. ethno specific; gender specific) |  |
| **Arrival details** |
| Date of arrival in Australia |  |
| Visa type |  |
| Countries of transit |  |
| Refugee camp abroad  | **YES / NO** | Duration in camp (if known) |  |
| Detention in Australia | **YES / NO** | Detention duration (if known) |  |

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| **Client Contact details** |
| Address |  |
| Suburb |  | Postcode |  |  |  |  |
| Contact number (1) |  |
| Contact number (2) |  |
| Email (if known) |  |
| Next of kin details(name; relationship, contact numbers) |  |
| Caseworker details(name; organisation, contact numbers) |  |
| **GP details** (if known) |
| GP name |  |
| GP telephone numbers |  |
| GP address, suburb; postcode |  |
| GP language other than English |  |
| **Health information** |
| Current health issues/ or concerns |  |
| Health alerts | **YES / NO** | If yes, **RED / GENERAL** |
| Health Undertakings | **YES / NO**  | If yes, has Health Undertaking Service been contacted? **YES / NO** |
| Health manifest available  | **YES / NO** |
| Detention Health discharge summary available | **YES / NO** |
| **Referrer details** |
| Name |  |
| Email |  |
| Organisation (if applicable) |  |
| Relationship to client (e.g. caseworker, sponsor)  |  |
| Contact numbers |  |

**Please complete the following details for each family member you would like included in the assessment:**

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| **Other family member’s details** |
| Surname |  |
| First name |  |
| Other names |  |
| Date of birth |  |
| Gender | **MALE / FEMALE** |
| Medicare Number (include position number on card) |  |  |  |  |  |  |  |  |  |  |  |
| Health care Card Number |  |  |  |  |  |  |  |  |  |  |  |
| Current health issues/ or concerns |  |
| Health alerts | **YES / NO** | If yes, **RED / GENERAL** |
| Health Undertakings | **YES / NO**  | If yes, has Health Undertaking Service been contacted? **YES / NO** |
| Health manifest available  | **YES / NO** |
| Detention Health discharge summary available | **YES / NO** |

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| **Other family member’s details** |
| Surname |  |
| First name |  |
| Other names |  |
| Date of birth |  |
| Gender | **MALE / FEMALE** |
| Medicare Number (include position number on card) |  |  |  |  |  |  |  |  |  |  |  |
| Health care Card Number |  |  |  |  |  |  |  |  |  |  |  |
| Current health issues/ or concerns |  |
| Health alerts | **YES / NO** | If yes, **RED / GENERAL** |
| Health Undertakings | **YES / NO**  | If yes, has Health Undertaking Service been contacted? **YES / NO** |
| Health manifest available  | **YES / NO** |
| Detention Health discharge summary available | **YES / NO** |