FocusOne Health
General Health Referral Form

Referrer to complete and send to FocusOne Health on: (08) 8582 3190 or e-mail: referrals@focusonehealth.com.au

FocusOne Health General Health program referring to:
Please tick the program you are referring the client to

☐ Integrated Primary Care (IPC)
☐ Closing the Gap Riverland (CTGR)
☐ Healthy Habits
☐ Bereavement Service Navigation
☐ Adult Community Education (ACE)

Referral required for *(e.g. allied health service, chronic disease management, weight loss, grief, employment support)**:***

1. Client Details

Name:	**DOB:**
Preferred Name:	
Gender: ☐ Male ☐ Female ☐ Other ☐ Not stated	
Residential address:	**Postal address:**
Home Phone:	**Mobile:**

Do you identify as:
☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

If Yes, Does the client have an ATSI Health Check (715):
☐ Yes ☐ No ☐ N/A
Date completed:

Country of Birth:
☐ Australia ☐ Other

Language Spoken:
☐ English ☐ Other
☐ Interpreter Required

2. Emergency Contact

Name: **Phone:**
Relationship to client:

FocusOne Health has permission to contact and share personal information with the Emergency Contact if required ☐ Yes ☐ No

3. Client Consent

FocusOne Health is a voluntary service, and all clients must consent to, and be willing to engage in services. The client consents to being referred for FocusOne Health services ☐ Yes ☐ No

For referrals to **Bereavement Service Navigation** and **Adult Community Education (ACE)**, Sections 4, 5 and 6 **do not** need to be completed.

GP/Nurse Practitioner Use Only

The following sections 4, 5 and 6 are **required** only for **Healthy Habits, Closing the Gap Riverland** or **Integrated Primary Care** referrals.

4. Medical History

GPMP / Health Summary / Pathology Attached: ☐ Yes ☐ No ☐ N/A

GPMP Review Date: **EPC Details**: ☐ N/A

Chronic Condition Details:	
☐ Arthritis	☐ Diabetes
☐ Asthma	☐ High Cholesterol
☐ Cardiovascular Disease	☐ Hypertension
☐ Chronic Obstructive Pulmonary Disease (COPD)	☐ Obesity
☐ Chronic Pain	☐ Osteoporosis
☐ Chronic Renal Disease	☐ Neurological Condition
☐ Mental Health Condition	☐ Other: _____
	☐ N/A

5. Observations

• Pain Score: /10	• Lipids:
• Spirometry: FEV1:	• eGFR:
• Pulse:	• Urine ACR:
• BP: /	• Weight: kg
• Cholesterol:	• Height: cm
• HbA1c%:	• BMI: kg/m^2

6. GP Exercise Clearance

Lifestyle Modification Contraindications:

I confirm that I have informed the client of the potential risks and benefits of participating in an exercise program. I have assessed their suitability for exercise and confirm they are suitable to participate in supervised, low to moderate intensity exercise programs delivered by a suitably qualified professional.

I have outlined any relevant limitations, precautions, or considerations for their participation below (e.g. recent MI, light exercise only)

_____

_____

The referrer recommends this client is suitable to participate in physical activity ☐ Yes ☐ No

If in doubt a specialist opinion may be necessary before participating in the program. Please note, the Care Coordinator may refer back to the GP if any contraindications arise during the program.

7. Referrers Details

Date of Referral:	**Referrers Name (GP):**
Organisation:	**Phone Number:**
GP Signature:	**Nurse Practitioner Signature:** (***For IPC referrals only**, GP signature is required within 6 weeks of referral)

Further information on the FocusOne Health General Health programs can be found on the FocusOne Health website: www.focusonehealth.com.au or by contacting the head office (08) 8582 3823.