COMMUNITY REHAB ALLIANCE
Referral Form

Phone: 4745 4525 **Email: nwcr.admin@jcu.edu.au**

NWHHS URN:_____

Participant's Name:		**Participant's D.O.B.:**	
Participant's Address:		**Participant's Medicare Card Details:**	**Card No.:**
Participant's Phone No.:			**Ref No.:**
Participant's Email:			**Expiry Date:**
Interpreter Required? ☐ **Yes** ☐ **No** **If yes, specify language:**		**Ethnicity:**	
Carer's / NOK Name:		**Carer's / NOK Phone:**	
Referrer's Name:		**Referrer's Organisation:**	
Referrer's Address:		**Referrer's Phone No.:**	

Date of Referral:

Rehabilitation goal/s:

Suggested rehab program:

☐ Individual therapy and / or

☐ Therapy group (please specify)

- ☐ Functional mobility group (Best Foot Forward)
- ☐ Arm and hand gym
- ☐ Self-management after brain injury (STEPS)
- ☐ Healthy aging for Indigenous Elders (Mamas & Papas)
- ☐ Other:

Diagnosis:

Allergies: ☐ Yes ☐ No

Current Medications:

Usual GP:

Practice: **Phone:**

What other services are you receiving? (please specify)

☐ Hospital:

☐ North West Remote Health:

☐ NDIS:

☐ Gidgee:

☐ Other:

Transport Assistance required? ☐ **Yes** ☐ **No**

Ability to Participate in Programs

This section needs to be completed by a Medical Officer*

Is the participant medically safe to partake in a physical activity program? ☐ Yes ☐ No

Are there precautions/restrictions/limitations that need to be observed during the program? ☐ Yes ☐ No

If yes, please specify:

Have you attached details of:

- **health condition? ☐ Yes ☐ No**
- **comorbidities? ☐ Yes ☐ No**
- **relevant medical/surgical history? ☐ Yes ☐ No**
- **current medications? ☐ Yes ☐ No**

Medical Officer's Name: _____

Provider No.: _____

Signature:_____

Contact details / stamp:

Please complete & email to nwcr.admin@jcu.edu.au along with any other relevant information e.g. discharge summary

Referrer's Signature: _____ **Date:** _____