

Consent/Referral Form

Patient/Client details

Title:		Address:
Last Name:		
First Name (s):		Suburb:
DOB:	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Postcode:
Health care card <input type="checkbox"/> Concession Card <input type="checkbox"/>		Telephone: Home: Work: Mobile:
Alternate Person Contact Details :		

Referral Information

Current MBS Items <input type="checkbox"/> 721 GPMP <input type="checkbox"/> 723 TCA <input type="checkbox"/> 900 HMR	Date	
Reason for referral		

Patient information and consent for use of personal information

My GP has explained the purpose of this referral for care coordination. I give permission for my medical information to be shared with the care coordinator at Perth Primary Network and other service providers as appropriate. I understand that this information will be kept in a way that protects my privacy and that some information that does not identify me may be given to the WA General Practice Network and the Department of Health and Ageing so that the program can be monitored and evaluated.

Patient Signature:	Preferred Contact:
Date:	Day: Time: Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile

Referring General Practitioner

PIP IHI registered

GP Details (or stamp) Name: Practice: Phone: Email:	Preferred Contact Day: Time: Phone: <input type="checkbox"/> Work <input type="checkbox"/> Mobile <input type="checkbox"/> Email
GP Signature:	Referral Date:

Please fax completed form to Perth Primary Care Network on 08 9279 8221.