



REFERRAL FORM – Healthy Directions PLUS
HBF patients with hospital cover only

ID No:
Office use only

Patient/Client details

Title:	Given Name:	Family Name:	
Street Number:	Street Name:	Suburb:	Postcode:
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Country of Birth:	
Telephone: (H)	(W)	(Mobile)	
Email:			

Eligibility Criteria

<input type="checkbox"/> HBF membership with hospital cover, longer than 12 months, and <input type="checkbox"/> One of the below referral diagnoses, and <input type="checkbox"/> Current TCA (MBS item 723) (preferred)	Date claimed:
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Referral Diagnosis (select one diagnosis only)

Results (attach relevant results as required)

<input type="checkbox"/> Asthma, moderate to severe	Spirometry
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease	Spirometry
<input type="checkbox"/> Congestive Heart Failure	Cholesterol
<input type="checkbox"/> Coronary Artery Disease	Cholesterol / fasting glucose
<input type="checkbox"/> Diabetes, type 1 or type 2	HbA1C / Fasting glucose / cholesterol
<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Osteoarthritis	
<input type="checkbox"/> Osteoporosis	Vitamin D

Generic clinical information (or attach summary sheet & relevant results)

Relevant Medical History	Current Medications



Patient may have up to a total of 10 HBF funded allied health sessions. Please indicate the number of sessions for each service provider.

Number of sessions	Provider	Number of sessions	Provider
	Audiology		Occupational Therapy
	Chiropractic		Osteopath
	Diabetes Education		Physiotherapy
	Dietetics		Podiatry
	Exercise Physiology		Psychology
	Mental Health Worker		Speech Pathology

Patient information and consent for use of personal information

My GP has explained that the purpose of this referral is for assessment and program(s) offered by HBF and Perth Primary Care Network (PPCN). I give permission for my medical information to be given to PPCN service providers as appropriate.
 By signing below I understand that this information will be kept in a way that protects my privacy and that some information which does **not** identify me may be given to Curtin University for evaluation purposes.
 I have HBF membership with hospital cover.

Patient signature:	Preferred contact
Date:	Day: Time: Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile, or <input type="checkbox"/> Email

Referring General Practitioner

GP Details (or stamp) Name: Practice: Phone: Email:	
GP Signature:	Referral Date:

**Please fax completed form to Perth Primary Care Network on 9279 8221 with:
 Copy of team care arrangement
 Summary of relevant medical history
 List of current medications
 Other test results as relevant**