This PDF will expire on 1 May 2024

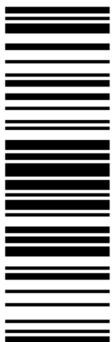
Health
Northern Sydney
Local Health District

Facility: COM HKH MQE MVH RNS RYD

INTELLECTUAL DISABILITY HEALTH SERVICE REFERRAL

FAMILY NAME		MRN	
GIVEN NAME		MALE	FEMALE
D.O.B. DD / MM / YYYY	M.O.		
ADDRESS			
		PH	
M/C	FIN		
LOCATION / WARD		ADM DD / MM / YYYY	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE



COR5205

To be completed by the treating Medical Officer.

Referrals to the specialised Intellectual Disability Health Service for eligible clients will be accepted on the basis that the referring Medical Officer retains case management, implements recommendations and follows through with care.
The service does not provide ongoing care or routine reviews.

Client Information

Client's Name .... Date of Birth: __ / __ / ____

Address .... Gender: Male Female Other

Phone .... Mobile ....

Email ....

Person to Contact 1

Name .... Relationship to client: ....

Phone .... Mobile ....

Medical Officer Referring

Name .... Provider Number ....

Address .... Postcode ....

Phone .... Email ....

Date of referral: __ / __ / ____ Signature ....

Practice stamp

General Practitioner (if different to above)

Name ....

Address ....

Phone .... Mobile ....

Email ....

Does the contact person/guardian or person responsible (as appropriate) consent to this referral: Yes No Don't know

Does the person identify as Aboriginal or Torres Strait Islander: Yes No Don't know

National Disability Insurance Scheme (NDIS) participant: Yes No Don't know

Is the person currently in hospital: Yes No Don't know

If yes, Medical Record Number (MRN) ....

Is the person's intellectual disability: Mild Moderate Severe Don't know

Holes punched as per AS2828.1:2019

BINDING MARGIN – NO WRITING

CATALOGUE NUMBER NS12440C-E APR22/V3

REFERRAL - IDHS

MARGIN – NO WRITING

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About the Referral (This information is important for the team in considering the referral)

What is the concern?

Not Urgent/Serious Urgent/Serious

Has the person already seen someone about this concern? Yes No Don't know

Who? ....

What happened? ....

Has the person been seen by the Intellectual Disability Health Service before? Yes No Don't know

Has the person been seen by the Intellectual Disability Mental Health Service before? Yes No Don't know

Genetic conditions:

Health conditions:

Behaviours of concern:

Additional information:

Person who will complete the Client Information Questionnaire (if different to person to contact)

Name .... Relationship to client ....

Phone .... Mobile ....

Email ....

If you have any questions you can contact us at:
(02) 9926 5777 or NSLHD-Intellectualdisability@health.nsw.gov.au

Office Use Only:

Eligible Appointment on : __ / __ / ____ with ....

at ....

Not Eligible Reason .... Date referrer advised: __ / __ / ____

BINDING MARGIN – NO WRITING

Holes punched as per AS2828.1:2019

MARGIN – NO WRITING