CDS
Centre for Disability Studies

Complex Care Service
Centre for Disability Studies
Ph: 0434 121 767
Email: ccs@cds.org.au

COMPLEX CARE SERVICE
REFERRAL FORM

Referrals to the Complex Care Service can be made by the person's general practitioner (GP), health professional, service provider or the person's family / primary carer.

If the referral is accepted, it is on the basis that the persons GP will retain ongoing medical care for the person, will implement recommendations and follow through with care.

Client Information		
First Name:	Last Name:	
Preferred Name:	Date of Birth:	
Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Do not wish to disclose ☐ Other (please specify) _____		
Address:		
Phone:		
Email:		
Does the person identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Neither		
Other Cultural Background:		
Is an interpreter required?	☐ Yes	☐ No
If yes, please specify:		

Main Contact Person / Guardian / Person Responsible			
Name:	Relationship:		
Address:			
Phone:	Email:		
Will the contact person / guardian / person responsible provide consent for this referral (if appropriate)	☐ Yes	☐ No	☐ Unknown

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Medicare Card Number:										
Reference Number:					Expiry Date:					

General Practitioner	
Name:	Provider Number:
Address:	
Phone:	Email:

Person Referring (if different to above)	
Name:	Provider Number (if relevant):
Address:	
Phone:	Email:
Date of referral:	Signature

Reason for Referral (including current concern/s to be addressed & what input has been provided to date)		
Are there any concerns regarding the person's mental health or behaviours of concern?	☐ Yes	☐ No
If yes, please specify:		

Comprehensive Health Assessment		
Has the person had a Comprehensive Health Assessment completed by their GP in the past 12mths? If yes, please provide a copy of the assessment and date if known: _____		
☐ Yes	☐ No	☐ Unknown

Access to Intellectual Disability Health Services		
Has the person accessed services from their local Intellectual Disability Health Service previously:		
☐ Yes	☐ No	☐ Unknown

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Has the person accessed any other intellectual disability health services in the past:		
☐ Yes	☐ No	☐ Unknown
If yes, please specify:		

Is the person's intellectual disability				
☐ Mild	☐ Moderate	☐ Severe	☐ Profound	☐ Unknown

Client Health Information
Medical Conditions:
Past Medical History:
Relevant Family Medical History:

Medications		
Current medications (including dosage & frequency)		
Does the person have any allergies?	☐ Yes	☐ No
If so, please provide further details:		

Person who will complete the Client Intake Form upon Acceptance of Referral	
Name:	Relationship:
Phone:	Email:

Once completed, please send a copy of this Referral Form to the Complex Care Service via email – ccs@cds.org.au