Maaruma-Li

ABORIGINAL MEDICAL SERVICE

HEAL • FIX • MAKE BETTER

NAME _____

SURNAME _____

OTHER NAMES _____

ADDRESS _____

DATE OF BIRTH _____ M ☐ F ☐

PHONE : H _____ Mobile _____

REFERRED BY _____

DATE _____

AGENCY _____

PH: _____

Email address _____

MEDICARE NUMBER _____

GP OR USUAL HEALTH PROVIDER _____

ALLERGIES AND ADVERSE REACTIONS _____

PRIMARY DIAGNOSIS OR PRESENTING CONDITION _____

URGENCY OR TRIAGE CATEGORY

(PLEASE CIRCLE) HIGH MEDIUM LOW

REASON FOR REFFERAL: _____

Bail condition ☐ Health Services ☐ Domestic/Family Violence ☐ AOD Support ☐ Other ☐

Cultural Health ☐ Disability ☐ Case Managment ☐ Housing ☐ Mentall Health ☐

CLIENT/CARER/GUARDIAN AWARE OF / AGREE TO REFERRAL YES ☐ NO ☐

Is client of Aboriginal or Torres Islander origin? YES ☐ NO ☐

Phone Notification Made Yes ☐ No ☐ Commencement date requested:

Are there any WH&S concerns for staff associated with this referral? YES ☐ NO ☐

Details _____

PRESENT MEDICATIONS (including alcohol and other drugs) _____

PAST HISTORY

Court orders or charges ☐	Care plan ☐	Victim services ☐
Discharge planning documentation ☐	Public Guardianship ☐	Community Corrections Order ☐
Release planning documentation ☐	NDIS Plan ☐	Community Treatment Order ☐

Please provide details ie. Justice Health/LHD/NGO _____

OTHER COMMUNITY HEALTH SERVICES INVOLVED/ OTHER RELEVANT INFORMATION _____

INTAKE INFORMATION: Contact Date: Contact Time: Signature:

Consent to collect and store personal and health information Yes ☐ No ☐

Consent to share with named services or sectors Yes ☐ No ☐

Consent for coordinated care Yes ☐ No ☐

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AGENCY _____
PH: _____
Email address _____

NEXT OF KIN OR EMERGENCY CONTACT
NAME _____
RELATIONSHIP TO CLIENT _____
PHONE _____
ALTERNATE PHONE _____
ADDRESS _____
IS THIS PERSON SAFE TO CONTACT REGARDING THIS REFERRAL

YES ☐ NO ☐

ANY CONTACT RESTRICTIONS OR INSTRUCTIONS _____

CONSENT AND AUTHORISATION

I authorise Maaruma-Li Aboriginal Medical Service to collect, use, and store my personal and health information for the purpose of assessment, care and service delivery.
I authorise the sharing of my information with relevant health providers, Aboriginal Community Controlled Organisations, and government agencies involved in my care where necessary for my safety, care and wellbeing.

I understand that:

- My information will be handled in accordance with the Privacy Act 1988 and the Health Records and Information Privacy Act 2002 NSW
- I may withdraw this consent at any time by notifying the service in writing
- Information may be used or disclosed without my consent where required or authorised by law, including where there is a serious risk to my health, safety, or the safety of others
- I understand I am not required to provide consent but this may limit the services available to me

I confirm that I have been informed of how my information will be used and have had the opportunity to ask questions.

Client or authorised representative name: _____

Signature: _____

Date: ____ / ____ / _____

If signed by representative, relationship to client: _____

Safe contact instructions (if applicable): _____