



**Queensland
Government**

**Referral to Townsville
Community Health Service
(TCHS)**

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Ph:

Date of birth:

Sex: M F I

Client Details

Indigenous status	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait <input type="checkbox"/> Both <input type="checkbox"/> Neither <input type="checkbox"/> Australian South Sea Islander		
Does the referral relate to	<input type="checkbox"/> WorkCover <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Defence <input type="checkbox"/> Vet Affairs → <input type="checkbox"/> Gold <input type="checkbox"/> White <input type="checkbox"/> Orange <input type="checkbox"/> Correctional Services <input type="checkbox"/> Government Pension <input type="checkbox"/> Disability Pension		
Disability status	<input type="checkbox"/> Intellectual/learning <input type="checkbox"/> Psychiatric <input type="checkbox"/> Sensory/speech <input type="checkbox"/> Physical/diverse <input type="checkbox"/> NDIS Plan <input type="checkbox"/> No disability		
Country of birth	<input type="checkbox"/> Australia <input type="checkbox"/> Overseas Main language spoken: <input type="checkbox"/> English <input type="checkbox"/> Other		
Accommodation	<input type="checkbox"/> Boarding house <input type="checkbox"/> Private residence – client or family owned/purchasing <input type="checkbox"/> Crisis, emergency or transition <input type="checkbox"/> Private residence – private rental <input type="checkbox"/> Independent living unit <input type="checkbox"/> Private residence – public rental <input type="checkbox"/> Indigenous community/settlement <input type="checkbox"/> Public shelter <input type="checkbox"/> Insitutional setting (i.e. hospital, residential aged care) <input type="checkbox"/> THHS funded supported accommodation e.g. TCCU, ABI, Correctional Centre <input type="checkbox"/> Other:		
Living arrangements	<input type="checkbox"/> Single (person living alone) <input type="checkbox"/> Sole parent with dependent(s) <input type="checkbox"/> Group (related adults) <input type="checkbox"/> Homeless/no household <input type="checkbox"/> Couple <input type="checkbox"/> Couple with dependents(s) <input type="checkbox"/> Group (unrelated adults)		
Client Function	1. Does the referred person have a moderate*, severe or profound disability, or a condition that limits, restricts or impairs everyday living activities**? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the referred person have difficulty performing core activities of daily living due to functional limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Is the referred person at risk*** of losing independence without the assistance of the requested service in the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No * Moderate is defined as a person needing no help, but has difficulty with a core activity task. ** Everyday living activities include: Walking Laundry Meal preparation Shopping Communication Self care e.g. showering Gardening Using public transport House cleaning Taking medication Toileting Managing finances *** A person is at risk if there is a potential for functional deterioration if they do not receive requested service.		
Carer/guardian	<input type="checkbox"/> Carer Name Ph Contact for appointment: <input type="checkbox"/> Guardian Name Ph <input type="checkbox"/> EPOA Name Ph <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Department of Child Safety Case Manager Ph		
Associated medical conditions	<input type="checkbox"/> Asthma/COPD <input type="checkbox"/> Cardiovascular disease/CVA <input type="checkbox"/> Musculoskeletal disease <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Renal disease <input type="checkbox"/> Bariatric weight kg <input type="checkbox"/> Neurological disease <input type="checkbox"/> Other <input type="checkbox"/> Cognitive impairment <input type="checkbox"/> Mental Health Condition		
Allergies/alerts	<input type="checkbox"/> Advance Health Directive <input type="checkbox"/> Risks/Hazards <input type="checkbox"/> Allergies Does the client have an infection control alert or been told they have a Multi-Resistant Organism? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other		
Consent	Consent for referral: <input type="checkbox"/> Yes		
Client's appointment preference	<input type="checkbox"/> Clinic <input type="checkbox"/> Home visit, provide reason <i>Please note home visit appointments are not available for all services listed.</i>		
Medications	<input type="checkbox"/> N/A <input type="checkbox"/> List attached		

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REFERRAL TO TOWNSVILLE COMMUNITY HEALTH SERVICE (TCHS)





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Important Information for Referrer

Eligibility criteria must be met. Please contact TCHS for full details of eligibility criteria if required.

All sections of this Referral Form are mandatory and are to be fully completed

Clients over 65 years of age refer to My Aged Care Ph: 1800 200 422

Exception applies to clients over 65 requesting post acute services

Intake Team
Townsville Community Health Service (TCHS)
Kirwan Health Campus

138 Thuringowa Drv, Kirwan QLD 4817
Phone: 4433 9500 Fax: 4433 9501
Email: THHS-KIRWAN-INTAKE@health.qld.gov.au

Services and Eligibility Criteria

Clinical Assessment	<input type="checkbox"/> Home Oxygen	>18 yrs of age
	<input type="checkbox"/> Community Nursing Assessment & Case Management	>18 yrs of age
	<input type="checkbox"/> Home Care	<65 yrs of age
	<input type="checkbox"/> Dementia Assessment Service	Any age. Comprehensive psychologist cognitive assessment
Clinical Care	<input type="checkbox"/> Dietitian	>18 yrs of age. Frail aged, malnutrition and chronic condition/s requiring dietary input. Provide latest pathology results for relevant chronic condition/s.
	<input type="checkbox"/> Exercise Physiologist	>18 yrs of age. Referrer must provide Echocardiograph/EF% results. Supports CROP & exercise groups. Home based exercise script also available.
	<input type="checkbox"/> Physiotherapy	>18 yrs of age. Balance, Mobility/ Falls Assessment, Equipment Trials, Acute muscular disorder. Continence Issues.
	<input type="checkbox"/> Occupational Therapist (OT)	>18 yrs of age. Excludes clients treated by Rehab, clients with acute injuries.
	<input type="checkbox"/> Podiatrist	All ages. High risk foot care, advise if wound is present.
	<input type="checkbox"/> Psychologist	>18 yrs of age. Clients must have chronic disease/s
	<input type="checkbox"/> Social Worker/Counselling	>18 yrs of age. Excludes transport and accommodation enquiries.
	<input type="checkbox"/> Speech Pathologist	>18 yrs of age. Includes communication voice, communication device, swallowing & palliative care
Education Programs <i>Clients/carers cognitive and communication able</i>	<input type="checkbox"/> Pulmonary Rehabilitation	>18 yrs of age. Provide Spirometry, arterial blood gases and chest x-ray results.
	<input type="checkbox"/> Cardiac Rehabilitation Education	>18 yrs of age. Partners and support persons welcome.
	<input type="checkbox"/> Bladder and bowel education	>18 yrs of age. Partners and support persons welcome.
Exercise Programs	<input type="checkbox"/> Cardiac Rehabilitation Exercise	>18 yrs of age. Clients must have completed Education Programme within past 12 months. Ejection fracture must be >40%. If <40% refer to Chronic Disease Exercise.
	<input type="checkbox"/> Chronic Disease Exercise	>18 yrs of age. Some exclusions apply based on assessment.
	<input type="checkbox"/> Hydrotherapy	>18 yrs of age. Excludes clients with contraindication to water exposure (ie. recent surgery, open wounds, unstable medical condition) or physical exercise.
	<input type="checkbox"/> Up & Go Program	Lower limb strengthening, transfers, sit to stand
Indigenous Care	<input type="checkbox"/> Child Hearing Health Screening	School age. Eligibility criteria.
	<input type="checkbox"/> Indigenous Cultural Consultation	>18 yrs of age. School age negotiable.
	<input type="checkbox"/> Indigenous Community Liaison Officer OPCS	≥50 yrs
Current Care Provision	Is this client currently receiving this service from another provider? <input type="checkbox"/> No <input type="checkbox"/> Yes - <i>specify below</i>	

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