Government of **Western Australia**
South Metropolitan Health Service

Statewide Care Navigator Service Referral Form

Date referral sent:		**Date referral acknowledged:** Office use only	

☐ **Urgent (< 1 week)** ☐ **Non urgent (> 1 week)**

Person/Patient information	
Family name:	**Given name(s):**
Date of birth (DD/MM/YYYY): / /	**Lives alone:** ☐ Yes ☐ No
Gender: ☐ Male ☐ Female ☐ Other (please specify)	
Home address:	
Suburb: **State:** **Postcode:**	
Home Phone: **Mobile:**	
Email:	
Patient location: e.g. Hospital, Home, Aged Care	**Religion:**
Is the patient of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander	
Interpreter required: ☐ Yes ☐ No	**If Yes, preferred language:**

Support person/Next of kin information	
Family name:	**Given name(s):**
Relationship to person:	
Home Phone: **Work:** **Mobile:**	

Referrer information		
Name of referrer: **Contact number:**		
Position/Organisation:	**Ward/Unit:**	**Discharge date:**
General Practitioner: **Contact number:**		
Is the GP/Physician aware of the referral? ☐ Yes ☐ No		

Diagnosis (Attach Relevant Medical Information)		
Date of Diagnosis:	**Primary Diagnosis:**	
Reason for Referral:	☐ Enquiry/Information request ☐ Care coordination ☐ Regional Access Support Scheme ☐ Seeking Practitioner	☐ Support request - Individual ☐ Support request - Family/Carer ☐ Other
Additional Commentary:		

Consent	
Has the person consented to the referral?	☐ Yes ☐ No
Is the family/carer aware of the referral?	☐ Yes ☐ No ☐ Don't know
Does the person have an Advance Health Directive?	☐ Yes ☐ No ☐ Don't know
Is there an Enduring Power of Guardianship?	☐ Yes ☐ No ☐ Don't know