

COMMUNITY HEALTH SELF-REFERRAL FOR SERVICES

Your personal details:

Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Master <input type="checkbox"/> Mx <input type="checkbox"/> Other:	
* D.O.B:	Gender:
* Given name:	
* Family name:	
* Street address:	
Postcode:	
* Contact phone number: Home	Mobile
* Do you hold a current Medicare card?	<input type="checkbox"/> Yes _____ - _____ <input type="checkbox"/> No
Do you hold a current Healthcare or Pension card?	<input type="checkbox"/> Yes _____ - _____ <input type="checkbox"/> No
Preferred medical practice:	
Preferred General Practitioner:	

Details marked with an asterisk (*) need to be completed

Please select what program/therapy:

Please tick one program/therapy each referral sheet

Programs

<input type="checkbox"/> Asthma Education Program	<input type="checkbox"/> Cardiac Rehab Group	<input type="checkbox"/> Happier, Healthier You Program
<input type="checkbox"/> Life! Program	<input type="checkbox"/> Men's Health Group	<input type="checkbox"/> Mums & Bubs Exercise Group
<input type="checkbox"/> Pulmonary Rehab Group	<input type="checkbox"/> QUIT Program	<input type="checkbox"/> Strength and Balance Group
<input type="checkbox"/> Tai Chi Group	<input type="checkbox"/> Yogatherapy	

Therapy

<input type="checkbox"/> Advance Care Planning	<input type="checkbox"/> Dietitian	<input type="checkbox"/> Exercise Physiology
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Well Women's Clinic
<input type="checkbox"/> Women's Health & Continence Physiotherapy		

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What are your health concerns:

Please help us in helping you by giving us some details about your medical needs

I currently have a NDIS package/in the process of creating an NDIS package

This form has been made for the community of Kyabram District Health Service for self-referring.

Clinicians and Nursing staff will need to complete a ConnectingCare referral or complete the following SCTT tools provided on the Health.Vic website (health.vic.gov.au).

- [Consumer Information](#)
- [Referral Cover Sheet & Acknowledgement](#)
- [Summary & Referral Information](#)
- [Consent to Share Information](#)

Practitioners are encouraged to complete a detailed referral letter with client's details.

Please sign and return this document to Kyabram District Health Service or email copy of this document completed to referrals@kyhealth.org.au

Signature		Date	
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For further information about our Community Health Services visit our website - www.kyhealth.org.au