PAEDIATRIC CENTRE GOLD COAST REFERRAL FORM

PERSONS DETAILS			
Title	**First Name**	**Surname**	**DOB**
Address			**Post Code**
Phone (home)		**Mobile**	
NOK	**Relationship**		**Tel/Mob**
Funding (Please Select) ☐ **Agency Fee** ☐ **Private Health Fund** ☐ **EPC** ☐ **PVT** ☐ **NDIS** ☐ **Other**			
Funding Details (e.g NDIS Participant Number)			
REFERRING ORGANISATION			
Agency/Organisation Name			
Contact Person		**Contact Phone Number**	
Email			
Reason for Referral/Diagnosis and Discipline Required			
Home or Clinic Visit Required			
Please Detail Patient Availability			
Best Time/Method to Contact Patient			
Is This Referral Urgent? <u>If Yes Must Detail</u>			
Do You Require Feedback Post Assessment or a Report? Please Specify *(note further charges may apply for a report)*			
Please Provide Quoted Fee if Applicable			
DOCUMENTATION (Please attach applicable supporting documents)			
☐ NDIS PARTICIPANT PLAN ☐ HOSPITAL DISCHARGE SUMMARY ☐ SPECIALIST REPORT/S ☐ GP HEALTHCARE SUMMARY ☐ GP REFERRAL FORM (EPC/PRIVATE LETTER) ☐ FUNDING APPROVAL			

Ph: (07) 5528 8617 Fax: (07) 5580 8374

Please email to community@alliedhealthservicesaustralia.com.au

Paediatric Centre Gold Coast