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

Statewide Care Navigator Service Referral Form

Phone: (08) 9431 2755
Fax: (08) 9431 2304
Email: VADcarenavigator@health.wa.gov.au

☐ **Urgent (< 1 week)** ☐ **Non urgent (> 1 week)**		**Date referral sent:**	
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:

Supporting clinical information such as outpatient letters and health summaries would be appreciated if available.

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