



**TOWNSVILLE HEALTH SERVICE DISTRICT  
REFERRAL  
OLDER PERSONS COMMUNITY SERVICES  
Phone: 0747 999 050 Fax 0747 999 521**

Title: Mr Mrs Miss Ms .....  
Surname: .....  
Given Names: .....  
Date of Birth: ..... Sex:  F  M  
UR No: .....

**Usual Address**

.....  
.....  
Suburb: ..... PCode: .....  
Telephone: ..... Mobile: .....

**Current Address** (if not at usual address)

.....  
.....  
Suburb: ..... PCode: .....  
Telephone: ..... Mobile: .....

**Main Contact**

Name: .....  
Address: .....  
.....  
Suburb: ..... PCode: .....  
Telephone: .....(hm).....(wk)  
Mobile: .....  
Relationship: .....  
EPOA Name: .....

**Indigenous Status**

Aboriginal  Torres St Islander  
 Both  Not either  
 **Aboriginal Liaison Officer Involvement**

**Marital Status**

Never Married  Widowed  
 Divorced  Separated  
 Married or De Facto

**Usual Accommodation Setting**

Private residence - owned / purchasing  
 Private rental  Public Rental  Other

**Living Situation**

Lives alone  Lives with family  
 Lives with others  Residential Care

**Country of Birth**

Australia  Other .....

**Language**

Preferred Language:  English  Other .....  
Interpreter Need:  Yes  No

**Pension Card Entitlements**

DVA:  Gold Card  Orange Card  White Card  
Pension:  Aged  Disability  Other  
 No Card

**Private Health Cover**  Yes  No

**Date of Referral:** .....

Client Aware of Referral:  Yes  No  
Client Consent:  Yes  No

**Person Referring Client**

Name: .....  
Address: .....  
.....  
Suburb: ..... PCode: .....  
Telephone: ..... Mobile: .....  
Relationship: .....

**Reason for Referral** (Please tick major reason only)

Permanent Care  Respite Care  
 CACP  EACH  
 Hospital: ..... Date of Admission: .....  
 ACFI: .....  
 **Transition Care Program**  
 **Home Care:** .....  
  
 **OPAHT:**  Dietitian  HV /  Clinic  
 Occupational Therapy  
 Physiotherapy  
 Podiatry  
 Speech Pathology

**Continence Advisor:**  
 HV /  Clinic

**Family to be present at assessment?**  Yes  No

**Contact Details**

.....  
.....  
.....

**General Practitioner**

Name: .....  
Address: .....  
.....  
Suburb: ..... PCode: .....  
Telephone: .....

**Alerts** (eg vicious dog) .....

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.....  
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