# Wellbeing Guide Western NSW referral form

Thank you for referring your client. To help us understand your client's needs, please complete all sections of this referral form.

| | | |
|---|---|---|
| Date of referral: | Referrer name: | Referrer phone: |
| Referrer email: | | |
| Referrer's profession/relationship to client (GP, Pharmacist, Physiotherapist, Occupational Therapist, Exercise Physiologist, Other Allied Health, Counsellors, Community Workers, informal supports, self): | | |
| Is the client aware of your referral? ☐ Yes ☐ No | | |

| **Client details** | | | |
|---|---|---|---|
| Title: | Family name: | First name: | Middle name: |
| Gender: | Date of Birth: | Estimated Date of Birth: | |
| Address: | | Suburb: | |
| Postcode: | Phone (home): | Phone (mobile): | |
| Country of birth: | | Preferred language: | |
| Aboriginal and/or Torres Strait Islander: ☐ Yes ☐ No ☐ Unsure | | Interpreter required: ☐ Yes ☐ No ☐ Unknown | |
| Does the client have chronic health conditions? ☐ Yes ☐ No ☐ Unsure | | | |
| If yes, what is the nature of their condition: | | | |

| **Emergency/alternate contact** | | |
|---|---|---|
| Name: | Relationship: | Phone: |

| **Referral details** | |
|---|---|
| Is the client over 65yrs or 50 and over for First Nations peoples? | ☐ Yes ☐ No * Must be yes to be eligible |
| Does the client experience social isolation: | ☐ Yes ☐ No * Must be yes to be eligible |
| Does the client have Aged Care supports? | ☐ Yes ☐ No ☐ Unsure |

| Does the client experience one or more of the following challenges? | |
|---|---|
| • People living in rural and remote communities with limited-service access to services | ☐ Yes ☐ No ☐ Unsure |
| • Have limited transport, mobility, or confidence to engage in community activities | ☐ Yes ☐ No ☐ Unsure |
| • Difficulty processing information to make decisions | ☐ Yes ☐ No ☐ Unsure |
| • People experiencing socioeconomic disadvantage or limited informal supports | ☐ Yes ☐ No ☐ Unsure |

*What information can you provide that will assist us in providing the most appropriate supports. Are there any barriers to accessing social supports, any chronic health information that may impact their ability to engage with services, or any general information that might assist in determining eligibility.*

| Consent | |
|---|---|
| *I consent to the referral being made on my behalf* | |
| Client signature: | Date: |
| Referrer signature: | Date: |

Marathon Health is committed to protecting your information, and any information we collect is used to facilitate the services we provide to you.

- In providing high-quality services, we collect personal health information and maintain a client record.
- We follow the Australian Privacy Principles (APPs) contained in the Privacy Act 1988 when handling, using and managing personal information.
- The APPs also outline your rights relating to accessing or correcting your personal information.
- We will not sell, transfer, assign or rent your information to any third party without your permission, unless required by law.

**Referrer acknowledgement**

*I have discussed the proposed referral with the client and/or authorised representative and am satisfied that the client and/or authorised representative understands the proposed collection, use and disclosure of personal health information and has provided informed consent to the proposed collection, use and disclosure.*

| *Referrer name* | *Referrer signature* | *Date* |
|---|---|---|

**Phone: 1300 402 585**
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