MUSCULOSKELETAL CONDITIONS REFERRAL FORM

BLACK SWAN HEALTH LTD

Incomplete referral form may result in processing delays and impact on the client's care coordination
Please sign and submit the completed form to info@blackswanhealth.com.au or fax to 9201 0033
Please refer to the Black Swan Health website for eligibility and exclusion criteria

BINDING MARGIN – NO WRITING

Date of referral: ___ / ___ / _____

1. CLIENT DETAILS

Title: _____ ☐ Male ☐ Female ☐ Other D.O.B: ___ / ___ / ____ *client must be over 18 to be eligible

Last Name: _____ First name: _____

Access issues: _____

Address: _____ Suburb: _____ Postcode: _____

Mobile: _____ Home: _____ Email: _____

Emergency / Next of Kin name: _____ Phone: _____

Is the client of Aboriginal and/or Torres Strait Islander descent? ☐ Yes ☐ No

2. REFERRAL INFORMATION

☐ GP ☐ Other health professional _____ - _____
please specify name / please specify profession

3. GP DETAILS (required to be completed for all referrals)

GP's name: _____ GP Stamp:

GP's practice: _____

Address: _____

Suburb: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

4. REFERRAL INFORMATION

a. Please tick the condition(s) that apply:

☐ Osteoporosis ☐ Osteoarthritis ☐ Rheumatoid arthritis
☐ Low back pain ☐ Heart disease ☐ Fibromyalgia
☐ Neck pain ☐ Post joint replacement ☐ Other: _____
please specify

b. Comments (please elaborate including date of diagnosis if known): _____

_____

_____

c. Any other relevant medical history: _____

_____

_____

d. Current medication: _____

_____

_____

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5. FURTHER REFERRAL INFORMATION - *Please tick as appropriate*

Please see attached the following documents:

- ☐ Relevant pathology results
- ☐ Current Team Care Arrangement (TCA)
- ☐ Current GP Management Plan (GPMP)
- ☐ **All referrals must be accompanied by a Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs** specifying the number of occasions of service required with the physiotherapist and / or the dietitian
- ☐ Other _____
  please specify

6. CONSENT TO REFERRAL – *Please tick the boxes below. Black Swan Health is only able to accept this referral where the client / guardian has consented to the referral, either verbally or in writing*

- ☐ My client has been assessed & meets the eligibility criteria for a referral to Black Swan Health
- ☐ I have obtained verbal consent from the client / legal guardian to refer and provide their personal health information to Black Swan Health for further assessment

Referrer signature: _____ Date: ___ / ___ / _____

Print Name: _____

OFFICE USE ONLY – leave blank
Unique client number (Black Swan Health to generate): _____

BINDING MARGIN – NO WRITING

Black Swan Health Limited (ABN 64 169 929 677)
t: 08 9201 0044 **f:** 08 9201 0033 **e**: info@blackswanhealth.com.au
Corporate office: 137-151 Main Street, Osborne Park, WA 6017
Service locations: Osborne Park | Joondalup | Midland | Fremantle
www.blackswanhealth.com.au