DIETETICS SERVICES
GP REFERRAL FORM

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 blackswanhealth.com.au for eligibility and exclusion criteria.

BLACK SWAN HEALTH LTD

BINDING MARGIN – NO WRITING

Date of referral: ____ / ____ / _____

1. CLIENT DETAILS

Title: _____ Gender: Male Female Other

Last Name: _____ First name(s):_____

D.O.B: ___ / ____ / _____ Access issues: _____

Address: _____

Suburb: _____ Postcode: _____

Mobile: _____ Home: _____ Email: _____

Emergency contact / Next of Kin name: _____ Phone: _____

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

2. GP DETAILS

GP Name: _____ GP Stamp:

GP Practice: _____

Address: _____

Suburb: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

3. REFERRAL INFORMATION

Reason for referral:

☐ Weight management
☐ Coeliac Disease
☐ Food intolerance/Allergy
☐ Irritable bowel syndrome
☐ Type 1 Diabetes
☐ Anaemia
☐ Gout
O Type 2 Diabetes
O At Risk of Type 2 Diabetes

☐ Other:
Please specify _____

BINDING MARGIN – NO WRITING

4. MEDICARE BILLING POLICY

If clients are referred under a Team Care Arrangement (TCA) they will be eligible for a Medicare rebate. Concession card holders will be bulk billed.

If clients wish to see us privately they can contact us on 9201 0044 to organise an appointment at one of our clinic locations.

☐ Client has GP Management Plan and TCA which is attached and includes the latest relevant pathology, investigations and anthropometric measures.

☐ Client has been allocated ___ (enter amount up to 5) Dietitian services with item number 10954 that are eligible for Medicare rebates this calendar year.

5. CONSENT TO REFERRAL

Please tick the appropriate boxes below. Black Swan Health is only able to accept referrals where the client / guardian has consented to the referral, either verbally or in writing.

☐ I consent to be referred to Black Swan Health and give permission for my referrer to be contacted

Client/Guardian Signature: _____ **Date**: ___ / ____ / _____

Print Name: _____

☐ I confirm my client has been assessed and 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's Signature: _____ **Date**: ___ / ____ / _____

Print Name: _____