

STRENGTH TO STRENGTH 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 the [Black Swan Health website](#) for eligibility and exclusion criteria

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. REFERRER INFORMATION

Self-referral GP (please provide GP details below) Other _____
please specify

3. GP DETAILS

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: _____

BINDING MARGIN – NO WRITING

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5. CONSENT TO REFERRAL – please select one of the two options below. Black Swan Health is only able to accept this referral where the client has consented to the referral, either verbally or in writing

a. GP REFERRALS ONLY – Please tick the boxes below

- I understand that for my client to be assessed and receive Medicare rebate, I have attached:
- a completed GP Management Plan (GPMP);
 - a completed Team Care Arrangement (TCA); and
 - a completed *Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs* for one occasion of physiotherapy.

Unless otherwise stated, clients will be encouraged to exercise between 60-80% of Maximal Heart Rate. Cardiac clients will have their BP and HR monitored and exercise will cease if BP > 180/100. Please provide the HR max/min parameters which the client may safely exercise for any concerns.

- 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: _____

b. SELF-REFERRALS ONLY – Please tick the boxes below

- I wish to refer myself to the Strength to Strength program run by Black Swan Health
- I understand that before being accepted into Strength to Strength program, I need to be assessed by a Black Swan Health Physiotherapist

Client signature: _____ **Date:** ___ / ___ / ___

Print Name: _____

OFFICE USE ONLY – leave blank

Unique client number (Black Swan Health to generate): _____

BINDING MARGIN – NO WRITING