

**Living Healthy Program**

Care Coordination, Diabetes Education, Dietetics, Exercise Physiology

**Client Details**

Name:	Home/Work Phone:
Address:	Mobile Phone:
DoB (over 18yrs only):	Email:
Identifies as: <input type="checkbox"/> Aboriginal <input type="checkbox"/> TSI <input type="checkbox"/> CALD	

**GP Details – referrals from GP/RAN/NP only with GPMP**

Name:	Phone:
Practice:	Email:
Practice Address	Fax:

**Eligibility Criteria – please tick relevant issues**

<b>Client has been diagnosed with:</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiac Condition <input type="checkbox"/> Respiratory Condition <input type="checkbox"/> Morbid Obesity	<input type="checkbox"/> Current GPMP Attached with referral including recent pathology <b>referrals will not be accepted without a current GPMP</b>
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**Allied Health Services Required – please tick**

<input type="checkbox"/> Care Coordination <input type="checkbox"/> Diabetes Education <input type="checkbox"/> Dietitian <b>Limited Service only</b> <input type="checkbox"/> Exercise Physiologist <b>Warren Blackwood Region only</b>
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**Reason For Referral**
**Consent**

I have discussed this referral and the information above with the client and consent has been provided for a referral to this program.

Client Name:	Client Signature:	Date
Referrer Name:	Referrer Signature:	Date

**Referrals to Fax: 9754 2985 or Healthlink (gpdsmhcc)**

**Inquiries to Program Coordinator on 9754 3662**

**PLEASE PROVIDE YOUR CLIENT A COPY OF THIS REFERRAL**

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