



REFERRALS

Referrals can be taken by email, faxed or phone.

We will call you on receipt of referral

Ph: 9906 7777 Fax: 9906 7766

www.archhealth.com.au

3/41 Herbert St, Artarmon NSW 2065

NAME OF CLIENT		D.O.B.	AGE
HOME ADDRESS		CONTACT DETAILS	
PLEASE CONTACT THIS PERSON AFTER THIS DATE/TIME:			
NEXT OF KIN		CONTACT DETAILS	
PRIVATE HEALTH FUND :		INSURANCE COMPANY, CONTACT NUMBER	
DVA NO#:	GOLD/ WHITE	CLAIM NO#	
DIAGNOSIS		GP NAME AND CONTACT DETAILS	
DISCIPLINE REQUIRED			
PHYSIOTHERAPY		AQUATIC PHYSIOTHERAPY	
OCCUPATIONAL THERAPY		MASSAGE	
EXERCISE CLASSES AND CLINICS		PODIATRY	
RELEVANT MEDICAL HISTORY		THERAPY REQUIRED	
HEART CONDITION	HISTORY OF FALLS	EQUIPMENT PRESCRIPTION	
CHEST CONDITION	ARTHRITIS	NEUROLOGICAL	
DIABETES	OSTEOPOROSIS	ORTHOPAEDIC	
EPILEPSY	JOINT REPLACEMENT	GERIATRIC	
NEURO. CONDITION	RECENT SURGERY	PRE/POST SURGICAL	
BOWEL/BLADDER	PREGNANCY	CARDIO-RESPIRATORY	
WEIGHT LOSS	MEDICATION CHANGE	MUSCULO-SKELETAL	
HISTORY OF CANCER	CHRONIC PAIN	OTHER	
TRANSPORT TO ARC		LEVEL OF MOBILITY	
CAR DRIVER		TRANSFERS: HOIST/ ASSIST/ AIDS/ INDEP	
CAR PASSENGER WITH CARER		WALKING: UNABLE/ ASSIST/ AIDS/ INDEP	
DROPPED OFF: TAXI/ DVA/ OTHER		REQUIRES CARE ASSISTANCE	
NAME OF REFERRER		CONTACT DETAILS	
COMMENTS			
CLIENT CONSENT TO SEND REFERRAL Y / N		DATE OF REFERRAL / /	