|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **about the individual being referred**  (click field to enter text) | | | ADAHPS_COLOUR_byline_SMALL  **REFERRAL FOR case management**  **SUbMIT to:** [Adahps@health.nsw.gov.au](mailto:Adahps@health.nsw.gov.au?subject=CONFIDENTIAL:%20Case%20Management%20Referral) | |
| **DATE of referral:** | | **NAME:**  **Medicare No:** |
| **DOB:**  **GENDER:**  male  female | | **ADDRESS:**  **STATE:**    **POSTCODE:**  **Phone:**  **LOCAL HEALTH DISTRICT: (if known)** | **Country of Birth:**  **identifies as:** Aboriginal  yes  no  Torres Strait Islander  yes  no **If yes, would they like an Aboriginal health worker:**   yes  no  **PREFERRED LANGUAGE:**  English   otheR (Specify):  **Intereter required:**  yes  no | |
| REASON FOR referral (select one or more) | | | **whAT CASE MANAGEMENT support required?**  Local support not available  Specialist advice  Medication adherence  Accessing care / service engagement  Linking with services  Practical assistance  Other (specify) | |
|  | Has moderate to severe HAND (HIV-associated neurocognitive disorders) or other HIV-related cognitive impairment (such as PML or Cerebral Toxoplasmosis) with significant functional impact | |
| **Far West NSW, Murrumbidgee, Southern NSW & Western NSW LHD residents only:** | | |
| Is HIV positive  Has co-morbidities  Has complex psychosocial issues | | |
| **WHAT IS THE INDIVIDUAL’S:**  Viral load \_\_\_\_\_\_\_ CD4 count \_\_\_\_\_\_ %\_\_\_\_\_\_\_\_ | | | **Is the client aware of the referral?**  yes  no If not, why? | |
| **OTHER INFORMATION YOU CONSIDER IMPORTANT** | | | | |
| **REFERRER DETAILS** | | | | **alternative CONTACT** |
| **NAME:**  **organisatioN:**  **ADDRESS:**    **State: Postcode:**  **PHONE: EMAIL:** | | | | Adahps’ intake officer will call to discuss the referral. This may take several minutes. If you would prefer that we speak with someone else (e.g. practice nurse/social worker) provide their details below:  **NAME:**  **POSITION:**  **PHONE:** |