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| --- | --- |
| **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 |
| **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:** |