NSW GOVERNMENT Health
South Eastern Sydney
Local Health District

Facility: Adahps

REFERRAL FOR CASE MANAGEMENT

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date of Referral:	Is the client aware of the referral? ☐ Yes ☐ No *If no* → Why?

CLIENT DETAILS

Gender at birth: ☐ Male ☐ Female ☐ Intersex ☐ Unknown

County of birth:

Phone

Preferred language	Interpreter required? ☐ Yes ☐ No

Aboriginal and/or Torres Strait Islander origin? ☐ Yes ☐ No ☐ Decline to respond ☐ Unknown

If yes → ☐ Aboriginal origin ☐ Torres Strait Islander origin ☐ Both

Medicare Number:	Valid to:

REFERRER DETAILS

Name:	Organisation:
Address:	
State Postcode	Phone
Email:	

HIV STATUS

Viral load:	CD4 count:

ELIGIBILITY CRITERIA

Local Health District (LHD):	**LHD Eligibility Criteria:**
☐ Sydney ☐ Illawarra Shoalhaven ☐ Northern NSW ☐ South Eastern Sydney ☐ Northern Sydney ☐ Central Coast ☐ Western Sydney ☐ Mid North Coast ☐ South Western Sydney ☐ Nepean Blue Mountains ☐ Hunter New England	☐ Has moderate to severe HIV-associated neurocognitive disorder and/or other HIV related cognitive impairment (such as PML or Cerebral Toxoplasmosis) ☐ Has significant functional deficit
☐ Far West NSW ☐ Murrumbidgee ☐ Southern NSW ☐ Western NSW	☐ Is HIV Positive ☐ Has co-morbidities ☐ Has complex psychosocial issues

REFERRAL REASON

☐ Needs specialist advice
☐ To access care/service engagement
☐ Local Support not available
☐ Other (specify):

☐ Not adherent to medication
☐ Practical assistance with day to day living
☐ Linking with services

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CLIENT FINANCIAL, LEGAL, and HOUSING STATUS

FINANCIAL

Employed: ☐ Yes ☐ No

Receiving a benefit: ☐ Yes ☐ No

If Yes → Specify:

HOUSING

Accommodation situation:

LEGAL

☐ Under Guardianship

☐ Under Financial Management

☐ Under legal order

☐ Probation/Parole

☐ Other (Specify):

HEALTH SUPPORTS

Does the client have a:

Case Manager:	☐ Yes	☐ No	*If Yes* → Details:
HIV/Sexual Health Physician:	☐ Yes	☐ No	*If Yes* → Details:
Usual Treating Facility:	☐ Yes	☐ No	*If Yes* → Details:
GP:	☐ Yes	☐ No	*If Yes* → Details:
Other Doctor/Health Professional:	☐ Yes	☐ No	*If Yes* → Details:

Other important information:

REVIEW *(Adhaps Use Only)*

Is the condition HIV related?	☐ Yes	☐ No
Is there significant functional impairment?	☐ Yes	☐ No
Is the client a resident of NSW?	☐ Yes	☐ No
Does the client have comorbidities?	☐ Yes	☐ No
Does the client have complex psychosocial issues?	☐ Yes	☐ No

Other comments:

NO WRITING