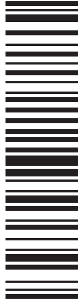
South Eastern Sydney Local Health District

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	



SES010205

When completed email to: seslhd-abc@health.nsw.gov.au

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

CLIENT DETAILS

Alias:	Phone:

Sex at Birth: ☐ Male ☐ Female ☐ Indeterminate ☐ Unknown ☐ Not Specified

Gender: ☐ Male ☐ Female ☐ Nonbinary ☐ Gender Nonconforming ☐ Prefer not to say

County of birth:

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 eligible? ☐ Yes ☐ No Medicare number: Valid to:

REFERRER DETAILS

Name:	Organisation:
Address:	
State: Postcode:	Phone:
Email:	

HIV BLOOD RESULTS

Viral load: Date:	CD4 count: Date:

ELIGIBILITY CRITERIA

Local Health District (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

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

S1145A 260723

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SES010.205

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Local Health District

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GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _______ / _______ / ________	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CLIENT FINANCIAL, LEGAL and HOUSING STATUS

FINANCIAL

Employed: ☐ Yes ☐ No

Receiving a benefit: ☐ Yes ☐ No

If Yes → Specify:

LEGAL

☐ Under Guardianship ☐ Probation/Parole

☐ Under Financial Management ☐ Under legal order

☐ Other (Specify):

HOUSING

Accommodation situation:

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:
NDIS:	☐ 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:

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

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NO WRITING