

## HEALTH PROFESSIONAL REFERRAL

RETURN THE COMPLETED FORM TO:  
Fax: 1300 013 242  
or Email: [contactsa@gethealthy.org.au](mailto:contactsa@gethealthy.org.au)

Simply call **1300 806 258**  
[www.gethealthy.sa.gov.au](http://www.gethealthy.sa.gov.au)

**Disclaimer:** By completing this form you consent to this information being sent to the Get Healthy Information and Coaching Service®, and consent for the Service staff to contact you.

### Referrer Details (print or stamp below)

Name: \_\_\_\_\_  
Profession: \_\_\_\_\_  
Organisation/Hospital: \_\_\_\_\_  
Address (for feedback letters):  
\_\_\_\_\_  
\_\_\_\_\_  
Postcode: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Email: \_\_\_\_\_

### Patient details

Please print or affix patient sticker on top

First Name: \_\_\_\_\_  
Surname: \_\_\_\_\_  
DOB: \_\_\_\_\_  
**Gender:**      Female      Male  
Address: \_\_\_\_\_  
Suburb: \_\_\_\_\_  
Postcode: \_\_\_\_\_  
Tel. home: \_\_\_\_\_  
Tel. mobile: \_\_\_\_\_  
Email: \_\_\_\_\_  
Are you of Aboriginal or Torres Strait Islander origin?  
No  
Yes, Aboriginal  
Yes, Torres Strait Islander  
Yes, both Aboriginal and Torres Strait Islander

### Preferred goal

Physical Activity      Weight Management  
Healthy Eating      Alcohol Reduction

### Is an interpreter required?

No      Yes

Specify language: \_\_\_\_\_

### When is the best time to call?

am      pm

### Are you pregnant?

No      Yes

### General comments

Please describe any health condition(s)/  
impairment(s) which may affect what the patient  
can eat or how physically active they can be:

### Current body measurements (Optional)

Waist circumference (cm): \_\_\_\_\_

Height (cm): \_\_\_\_\_

Weight (kg): \_\_\_\_\_

### If pregnant:

Pre-pregnancy weight (kg): \_\_\_\_\_

Gestational Age (wks): \_\_\_\_\_

### Feedback letters (optional)

I, the health professional named above, would like feedback letters on the above patients contact with the Service.

Date: \_\_\_\_\_