

GENERAL PRACTICE REFERRAL

RETURN THE COMPLETED FORM TO:

Fax: 1300 013 242

or Email: contactsa@gethealthy.org.au

Simply call **1300 806 258**
www.gethealthy.sa.gov.au

General Practice Details (print or stamp)

Doctor Practice Nurse/Registered Nurse

First Name: _____

Surname: _____

Address: _____

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 pregnant? No Yes

Are you of Aboriginal or Torres Strait Islander origin?

No

Yes, Aboriginal

Yes, Torres Strait Islander

Yes, both Aboriginal and Torres Strait Islander

Is an interpreter required? No Yes

Specify language: _____

When is the best time to call?

am

pm

Primary issue for referral

Physical Activity Weight Management

Healthy Eating

General comments

Please list any health conditions/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): _____

Patient consent and signature:

I consent to this information being sent to the Get Healthy Information and Coaching Service[®], and consent for the Service staff to contact me.

I understand that the General Practice named above will receive written feedback of my contact with the Service.

Signature: _____

Date: _____

GP, Practice/Registered Nurse signature:

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

The patient is fit to participate in the program

Name: _____

Signature: _____

Date: _____