

HEALTH PROFESSIONAL REFERRAL

RETURN THE COMPLETED FORM TO:

Fax: 1300 013 242

or Email: contact@gethealthynsw.com.au

Simply call **1300 806 258**
www.gethealthynsw.com.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
eats 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 patient's contact with the Service.

Date: _____