New Client/Referral Form

Pod Dietetics

Name *

First Name Last Name

Date of Birth *

Sex

Gender Identity

Phone Number - Primary Contact *

Area Code Phone Number

Email Address - Primary Contact *

This is for booking confirmation emails and any other email contact regarding our services. example@example.com

Primary Contact is:

Me (Client)
A family member
A support worker
A formal guardian

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Please add any relevant information about the best way to respond to this referral

Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Note:

Please avoid using the auto fill function as we have noticed this leads to some sections being filled out incorrectly or unnecessarily. Please read and fill in all relevant sections and attach any relevant documents.

Emergency Contact - Name *

Emergency Contact - Phone Number *

Area Code

Phone Number

Referral/Funding Type *

- National Disability Insurance Scheme (NDIS) - SELF MANAGED
- National Disability Insurance Scheme (NDIS) - PLAN MANAGED
- National Disability Insurance Scheme (NDIS) - AGENCY MANAGED
- Lifetime Support Authority (LSA)
- Return to Work SA (RTWSA)
- Medicare: Chronic Disease Management Plan
- Medicare: Eating Disorder Management Plan
- Department of Veterans Affairs

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Department of Veterans Affairs (DVA) Gold Card
Private Health Insurance
Self Referred/Funded
Concession Card Holder (Pension/Health Care) (Can be used in conjunction with Medicare referral)

Referral Background or Goals of Dietitian Support *

For NDIS participants please also include your NDIS Plan goals (or you can attach a copy of your plan or goals below)

Preference of appointment type

In clinic
Telehealth - video
Telehealth - phone
Home Visit (please ensure current home address is included) - additional charges apply. This is generally reserved for NDIS/LSA clients.

Preference for appointment reminder

SMS Text Message
Email

Attached Documents

Medical Summary (eg. hospital discharge, GP review, practice nurse assessment)
List of Medications
Recent blood test results (eg. vitamin or mineral screens, cholesterol, diabetes monitoring)
NDIS Plan or Goals
LSA Service Order
GP Team Care Arrangement or Chronic Disease/Eating Disorder Management Plan
Reports from other healthcare professionals (eg. swallowing assessment, exercise prescription, handover from previous dietitian)
DVA GP Referral

Referral submitted by

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Date

Month Day Year

If 'Other' please provide details

Referral/Funding Information

Please fill in the relevant information for your referral type below.

NDIS Participant Number

NDIS Plan Manager (Name and Email Address for billing)

NDIS Support Coordinator (Name and Contact Ph/Email)

NDIS Support Category

- Capacity Building: Improved Health and Wellbeing
- Capacity Building: Improved Daily Living
- Core Supports: Assistance with Daily Life

NDIS Plan Dates

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GP Name & Clinic Name

LSA Service Planner (Name and Contact Ph/Email)

RTWSA Case Coordinator (Name and Contact Ph/Email)

RTSWA Case Number

Medicare Number/DVA File Number

GP Name

GP Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Risk Assessment

For all Home Visits please fill in below Risk Assessment section

Medical Risks

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Are there any medical risks eg seizures, diabetes, communication aids, asthma, anaphylaxis, tracheostomy, enteral feeding.

Yes

No

If yes, please provide details below

Special Equipment Used

Eg. Wheelchair, lifter, gait aid, medical equipment, communication aids

Behaviour Risks

Is there a history of mental health concerns or a complex behaviour risk?

Yes

No

If yes, please provide details below

Mental health concerns, history of aggression/violence, self-harm, suicidal tendances, history of wandering or absconding, other behaviours?

Environmental Risks

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Tick those that apply

- Bushfire Zone
- Mobile Reception Unavailable
- Smoker(s) in the home
- Pets in the home
- Known weapons in the home
- Known substance use in the home
- Anyone at the premise prone to violence/aggression
- Obstructions/Tripping Hazards
- Other

Please provide details below

Type of Premises

House, Flat, Apartment (with lift/stairs), Supported Residential Facility etc.

Who else lives at the premises?

Partner, Children, Parents, Guardian etc

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