PHN NORTHERN QUEENSLAND
An Australian Government Initiative

Wheels of Wellness Referral Form

WOW Wheels of Wellness Mobile Clinic

REFERRER DETAILS

Name: Agency /Position:

Postal Address: Postcode:

Phone: Email:

APPLICANT TO COMPLETE

1. Your Details

First Name: Family Name: Date of Birth:

Preferred Name: Ethnicity:

Gender: ☐Male ☐Female ☐LGBTIQ ☐Other

Address: Postcode:

Phone: Mobile: Email:

Aboriginal: ☐Yes ☐No Torres Straight Origin: ☐Yes ☐No

Medicare Card Number: ______________________________ Ref: ______EXP: _______

Concession Card Number: ______________________________ EXP: __________ TYPE: Pension HCC

Culturally and Linguistically Diverse: ☐Yes ☐No Country of Birth: ______________________________

Main Language Spoken: ☐English ☐Other: ______________________________

Interpreter required: ☐Yes ☐No Visa Status: ______________________________

Living Situation: ☐Living Independently ☐Living with Family Member/Carer
☐Homeless ☐Other: ______________________________

Marital Status: ☐Single ☐Married ☐Separated
☐Divorced ☐Widowed ☐Defacto

Children: ☐Yes ☐No Occupation: ______________________________

Source of Income: ☐Age Pension ☐Carer Allowance
☐Disability Pension ☐Department of Veteran's Affairs
☐Family Assistance ☐Unemployment
☐Youth Allowance ☐Paid Work
☐Other (please specify):

Hold a DVA Card? ☐Yes ☐No If yes, what type? ☐Gold ☐White ☐Other

2. Contacts

Nominated Support Person (Next of kin / Alternative contact)

Name: Relationship:

Email: Phone: Mobile:

Wheels of Wellness
Referral Form

Do you have a Case Manager?	☐Yes ☐No	Name:
Email:	Phone:	Mobile:
Do you have a guardian?	☐Yes ☐No	Name:
Email:	Phone:	Mobile:

Do you have a Public Trustee? ☐Yes ☐No	Name:	
Email:	Phone:	Mobile:
Do you have a GP? ☐Yes ☐No	Name:	
Email:	Phone:	Mobile:

Which of the above is your preferred contact? ☐Support Person ☐Case Manager ☐Public Trustee ☐GP

3. Health and Wellbeing

3.1 Any mental health issues you currently receive treatment or support for? ☐Yes ☐No

If yes, when did you first receive treatment for this?

3.2 Any physical health concerns you currently receive treatment for? ☐Yes ☐No

If yes, how long have you received treatment for this?

Do you have any legal issues we need to know about? (i.e. outstanding charges, convictions or a community treatment order) ☐Yes ☐No

If yes, please provide details:

Do you have any Alcohol or Drug issues? ☐Yes ☐No

If yes, please provide details:

Are you linked with any Alcohol or Drug services? ☐Yes ☐No

4. Consent

I Consent to the disclosing of my personal and health information to Wheels of Wellness for the purpose of receiving Medical Care.

Signature: ____

Date: ____

*If Guardian, provide a copy of your Guardian Order issued by the State Health Tribunal.