Client Referral Form

Call 1800 254 354
(7am to 7pm, 7 days a week)

Client Details

Name

DOB

Age

Address

Phone

Alternate Contact

Client identifies as

Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Neither ☐

Referral date

Hospital URN

Medicare Number

Is the patient currently in hospital? Yes ☐ No ☐
Expected discharge date:

Has the patient consented to this referral? Yes ☐ No ☐

Has the patient consented to Mob Link accessing IUIH medical records if available? Yes ☐ No ☐

Reason for referral: Note: Please attach any supporting documents (ie Discharge summary, OT report)

Referrer Details

Name

Phone

Email

Organizations

Position

Department

Note: Contact cannot be made with patient until referral and consent is completed

Send referral via:
FAX: 3205 8666

EMAIL: moblink@iuih.org.au

IUIH Institute for urban indigenous health