



GREEK ORTHODOX COMMUNITY OF SA INC.
COMMUNITY CARE SERVICES
REFERRAL

Phone: (08) 7088 0500 Fax: (08) 8245 5586

DATE OF REFERRAL: ____/____/____

Priority Ranking:

Low

Medium

High

(Office use Only)

Title: _____ Given Names: _____ Surname: _____

Address: _____ Suburb: _____ State: _____ Postcode: _____

DOB: _____ Country of Birth: _____ Language spoken: _____

Phone: (H) _____ (Mob) _____

Marital Status: _____ Gender: Male ☐ Female ☐

GP Name: _____ Telephone _____

GP Address: _____

Pension Type: _____ CRN _____ Access Cab: Yes ☐ No ☐ Unknown ☐

Ambulance Cover: Yes ☐ No ☐ Medicare No: _____

ADDITIONAL INFORMATION

Accommodation: Home Owner ☐ Private tenant ☐ Public tenant ☐ Unit ☐ Other ☐ _____

Living Arrangements: Lives alone ☐ Lives with family ☐ Lives with spouse ☐ Lives with others ☐ Not stated ☐

Other Services involved: _____

MEDICAL INFORMATION

Medical History: _____

Medication: _____

REFERRAL INFORMATION

Reason for referral: _____

Referring Person (Name): _____ Organization: _____

Address: _____ Tel: _____

How did you learn about GOCSA's Programs:

Feedback to Referral Person: Yes No ☐

Client Aware of Referral: Yes No

REFERRAL TAKEN BY:

DATE: ____/____/____

Office Use only

Privacy Statement Read / Sent: Yes ☐ No ☐

Privacy Statement Date Advised: ____/____/____

Previous GOSA Record: Yes ☐ No ☐

Program _____

ACTION TAKEN:

• ALLOCATED TO: (Name) _____ DATE: ____/____/____

• PLACED ON WAIT LIST: YES ☐ NO ☐

• FOLLOW UP CALL RE: NOTES: _____

