Health
Sydney
Local Health District

NATIONAL CENTRE FOR VETERANS' HEALTHCARE

National Centre Veterans' Healthcare (NCVH) Referral Form

Site: Concord Repatriation General Hospital

Ph: (02) 9767 8669 **Fax: (02) 9767 8668**

SLHD-ConcordNCVHIntake@health.nsw.gov.au

NCVH Specialist Services

All patients referred to NCVH receive a comprehensive clinical intake assessment to assist with care planning. Referral to the NCVH Medical Director facilitates this process. Coordination of subspecialty services (Psychiatry, Drug Health, Rehabilitation, Pain Medicine) is informed by intake processes.

☐ **Dr Cameron Korb-Wells** (Medical Director, NCVH)

Referrer Details *(GP referral required)*

Referrer Name:	**Date of Referral:**
Organisation:	**Provider Number:**
Address:	
Phone Number: ( )	**Fax: ( )**
Email:	

Patient Details

Surname:	**Given Names:**
Sex: ☐ Female ☐ Male	**DOB:**
Address:	
Phone: ( )	**Email:**
Medicare Number:	
Medicare Expiry Date:	
Contact person:	**Relationship to patient:**
Contact person mobile:	**Other contact person details:**

Australian Defence Force (ADF) History

Patient is only eligible for NCVH services if he/she is a current ADF serving member or has served in the past.

Is patient a current service ADF member? ☐ Yes ☐ No

Has the patient served in ADF in the past? ☐ Yes ☐ No

DVA entitlements: ☐ Gold ☐ White ☐ No entitlement	**DVA Number:**
Years of service:	**Branch of service:** ☐ Air Force ☐ Army ☐ Navy ☐ Reserves
Field of ADF work:	**Number of Deployments:**

ADF discharge: ☐ Voluntary ☐ Non-voluntary | ☐ Medical grounds | ☐ Compulsory retirement age

ADF discharge summary: ☐ Yes *(please attach if available)* ☐ No

Receiving ongoing support or treatment relating to military service *(please attach notes if applicable)*:

☐ Yes ☐ No

BINDING MARGIN - NO WRITING

REORDER: PHOTOCOPY

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AMR005.007

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Referral Details

Reason for referral / diagnosis:

_____

_____

Medical History *(please attach additional details if required):*

_____

_____

_____

Mental Health Diagnoses *(please tick all applicable boxes)*:

☐ PTSD ☐ Depression ☐ Anxiety ☐ Panic attacks

☐ Substance use – current/past; which substance(s)_____

Other diagnoses:

_____

_____

Current Medications *(or attach):*

_____

_____

Is there a history of concussion or other head injury? ☐ Yes ☐ No

Are there ongoing issues following the head injury? ☐ Yes ☐ No

Details:

Has the patient experienced any issues with anger management? ☐ Yes ☐ No

Details:

Prior Medical Specialist Contacts *(please attach Care Plan if available)*:

1. Chronic Pain: _____ **4. Rehabilitation Medicine:** _____

2. Drug Health: _____ **5. Other:** _____

3. Mental Health: _____ _____

Other Comments:

_____

_____

***** Please attach any relevant investigation results and/or ADF Post-Discharge GP Health Assessment if available *****

Please mark here ☐ if you <u>do not</u> wish to provide a named referral to the service.

Referrer's signature: _____

Practice stamp (if applicable)

Office use only:

Date Received:	**1st contact:**	**Intake:**

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