Ethnic Communities Council of Queensland

Referral to ECCQ
Fax: 0738464453

Client Family Name: ______________________ Given Names: ______________________

Address: ______________________

Post code: __________ Telephone: __________ Mobile: __________

Date of Birth: __________ Country of origin: __________ Language/s Spoken: __________

☐ Male ☐ Female Date referred:

Client Consent Given? ☐ Yes ☐ No Reason if No, ______________________

Is the Client Motivated? ☐ Yes ☐ No Reason if No, ______________________

Referral related to

☐ At risk of type II diabetes

☐ Uncontrolled type II diabetes

☐ Two or more CVD risk factors

☐ BMI greater than 27

☐ High blood pressure (Systolic >140 mmHg or Diastolic >90mmHg)

☐ Uncontrolled Asthma

☐ Any other chronic disease, please specify ______________________

Risk Factors Assessed:

Waist circumference (cms)	Weight (kgs)	Height (cms)	BMI	BP	AUSDRISK score

Additional Information

Medical Issues: ______________________

Social Issues: ______________________

Desired Goal

Priority 1: __________ Priority 2: __________ Priority 3: __________

Referrer Details

Name: ______________________

Practice Address: ______________________

Post code: __________ Telephone: __________ Fax: __________ Email: __________

Referral to:
Ethnic Communities Council of Queensland
Chronic Disease Program Telephone: 07 3255 1540
Email: chronicdisease2@eccq.com.au
Website: www.eccq.com.au

DO NOT WRITE IN THIS BINDING MARGIN