Allied Health and Community Organisation

# Referral Form

Ethnic Communities Council of Queensland

| Client Details: | | | |
|---|---|---|---|
| Referral Date: | | Sex: | |
| Title: | | Age: | |
| Surname: | | Phone: | |
| Given Name/s: | | Email: | |
| Country of Birth: | | Language/s: | |
| Community: | | Post Code: | |

| Reason for referral to free education and support: | | | |
|---|---|---|---|
| Chronic Disease Prevention and Management | ☐ | Australian Health Care Information | ☐ |
| Nutrition Education | ☐ | Smoking and Alcohol Education | ☐ |
| Physical Activity Education | ☐ | Health Check | ☐ |
| Other _____ | | | |
| Additional Information: | | | |

| Referrers Details: | | | |
|---|---|---|---|
| Name: | | Phone: | |
| Organisation: | | Email: | |
| Address: | | | |

By signing this form, you are saying that you understand that you are giving consent to The Ethnic Communities Council of Queensland to give your personal information to staff member/s from the Chronic Disease Team to provide education and support requested

| Consent: | | |
|---|---|---|
| Clients Signature: | | Date: |
| Referrers Signature: | | |

Please fax or email the completed referral form to the
Ethnic Communities Council of Queensland Chronic Disease Program.

Ethnic Communities Council of Queensland: Chronic Disease Program
261 Boundary Street, West End 4101
Phone: 07 3255 1540
Fax: 07 3846 4453
Web: www.eccq.com.au
Email: chronicdisease2@eccq.com.au