

Chronic Disease Program

Referral Form



Referral Date:			
Surname:		Post Code:	
Given Name/s:		Age:	
Country of Birth:		Sex at Birth:	
Language/s:		Identify as:	
Community:		Mobile/Phone:	

Client Consent Given? Yes No Reason if No,

Is the Client Motivated? Yes No Reason if No,

Referral Related to:

High risk of Type II Diabetes

Two or more CVD risk factors

High Blood Pressure (>140mmHg Systolic or >90mmHg Diastolic)

Other chronic diseases (specify):

Uncontrolled Type II Diabetes

BMI greater than 27kg/m²

Uncontrolled Asthma

Risk Factors Assessed:

Waist circumference (cm)	Weight (kg)	Height (cm)	BMI	Blood Pressure	AUSDRISK Score

Additional Information:

Medical Issues:

Social Issues:

Desired Goal:

Priority 1:

Priority 2:

Priority 3:

Preferred Program:

My Health for Life

Health Navigation and Living Well Multicultural Program

The COACH Program for Multicultural Communities

No preference, as applicable

Referrer Details:

Name:

Organisation:

Phone:

Email:

Please fax or email the completed referral form to:

Ethnic Communities Council of Queensland: Chronic Disease Program

Email: chronicdisease2@eccq.com.au Fax: 07 3846 4453

Address: 253 Boundary Street, West End 4101 Phone: 07 3844 9166

