



ABN: 84 612 857 931

CASE MANAGER REFERRAL FORM

Please download, fill in and fax to 07 4573 1100 or email to referrals@ruralhealthconnect.com.au

Client Name	
Date of Birth	
Contact	
Is there any current mental health care plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	
GP Name	
Has client given consent to sharing their information? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If applicable, notes:	
Case Manager's Name	
Phone	
Email	
General information: Local emergency contacts, procedures and anything else of relevance.	

Please send this Referral Form to referrals@ruralhealthconnect.com.au

We are here to help. Please contact us with any enquiries or for assistance at **0427 692 377**

We look forward to working with you