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| **Metro South Hospital and Health Service**  **Metro South Oral Health**  **Refugee & Asylum Seeker Referral Form** | (Affix MSOH ISOH identification label here) |

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| **Client Details: Client Eligibility Details:** |

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| Title: <PtTitle> Sex: <PtSex>  Family name: <PtSurname>  Given name(s): <PtFirstName>  Date of birth: <PtDoB>  Address: <PtAddress>  Telephone: <PtPhoneH> <PtPhoneMob>  Country of Birth:[<Patient's Country of Birth>](#BPSFIELD|C|10|||)  Interpreter required: [<Interpreter required?>](#BPSFIELD|B|10|||)  Language spoken: [<Language Spoken>](#BPSFIELD|C|10|||)  Other or dialect requirements: [<Other or dialect requirements>](#BPSFIELD|C|10|||)  Interpreter preference [<Interpreter Preference>](#BPSFIELD|L|SINGLE||||Female|Male|No Preference) | Does the client go to school?: [<Does the client go to school?>](#BPSFIELD|B|10|||) [<If So, Name of school>](#BPSFIELD|C|10|||)  Is the client a Queensland resident: [<Is the client a Queensland resident?>](#BPSFIELD|B|10|||)  Arrival in Queensland: [<Arrival in Queensland>](#BPSFIELD|D|20|||)  Asylum seeker: [<Asylum seeker>](#BPSFIELD|X|10|||) Refugee: [<Refugee?>](#BPSFIELD|X|10|||)  Visa Type: [<Visa type?>](#BPSFIELD|C|10|||)  **Medicare Card details:**  Medicare Card No: <PtMCNo>  Reference No: <PtMCLine> Expiry date: <PtMCExpiry>  **Health Care Card or Pension Card details:**  Concession Card No: <PtPensionNo><PtDVANo><PtDVACard> |

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| **Preferred Dental Clinic** https://metrosouth.health.qld.gov.au/oral-health/clinics |
| Preferred Clinic: [<Preferred Dental Clinic>](#BPSFIELD|L|SINGLE||||Beaudesert OHC|Beenleigh OHC|Browns Plains OHC|Inala OHC|Kingston OHC|Logan Central OHC|QEII OHC|Redlands OHC|Woolloongabba OHC|Wynnum Manly OHC) |
| **Reason for referral** (urgent care, dental examination etc. Please give detailed clinical, social reasons, etc.) |
| [<Reason for referral>](#BPSFIELD|M|10|||) |
| **Referral From** |
| Name: <RefDetails> Position:  Agency: <Practice> Contact Number: <RefPhone> Contact Email:<RefEmail>  :  Date: <TodaysDate> |
| **Oral Health Staff Use Only** |

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| [<Demographics entered in ISOH>](#BPSFIELD|X|10|||)Demographics entered in [<Placed on Referral Waitlist Priority 1>](#BPSFIELD|X|10|||)ISOH Placed on Referral Waitlist: Priority 1  [<Dental assessment appointment made>](#BPSFIELD|X|10|||) Dental assessment appointment made [<Interpreter booked>](#BPSFIELD|B|10|||)Interpreter booked  [<Referral scanned into ECR>](#BPSFIELD|X|10|||)Referral scanned into ECR | Date of appointment: | Staff member name: |

**COVID screening questions for Refugees and Asylum seekers requesting Emergency Oral health care from MSOH**

1. Have you experienced any of the following in the last 7 days? [<Have they experience any COVID symptoms in last 7 days>](#BPSFIELD|X|10|||)

- Cough - Runny Nose - Shortness of Breath

- Fever - Fatigue - Sore throat - Loss of sense of smell or taste

2. Have you travelled interstate or overseas in the last 14 days? [<Have they travelled interstate or overseas in the last 14 days>](#BPSFIELD|X|10|||)

3. Have you been in contact with a person suspected or confirmed of having COVID-19? [<Have they been in contact with someone who is suspected of having COVID>](#BPSFIELD|B|10|||)If yes, date of most recent contact [<If yes, date of contact>](#BPSFIELD|D|10|||)

4. Have you been instructed to self- isolate or self-quarantine? [<Have they been instructed to self-isolate?>](#BPSFIELD|B|10|||)

**Refugees and Asylum seekers requiring Urgent Dental treatment from MSOH**

Please indicate the symptoms the patient is presenting with indicating urgent care

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| Trauma / Injury | [<Trauma / Injury>](#BPSFIELD|X|10|||) |
| Swelling in the face | [<Swelling in the face>](#BPSFIELD|X|10|||) |
| Swelling in the mouth | [<Swelling in the mouth>](#BPSFIELD|X|10|||) |
| Uncontrolled bleeding | [<Uncontrolled bleeding>](#BPSFIELD|X|10|||) |
| Pain | [<Pain>](#BPSFIELD|X|10|||) |
| Pain when eating | [<Pain when eating>](#BPSFIELD|X|10|||) |
| Broken Tooth | [<Broken Tooth>](#BPSFIELD|X|10|||) |
| Broken Denture | [<Broken Denture>](#BPSFIELD|X|10|||) |

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