



Please email form to <a href="mailto:referrals@qpp.org.au">referrals@qpp.org.au</a> . For further enquiries, please call 1800 636 241.			Referral Date: / /	
<b>Details of the REFERRER</b>				
Name:		Position:		
Organisation:		Contact Phone:		
Email address:				
Has the client consented to this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No*		*QPP is unable to provide services to a person where consent for the referral has not been obtained. Please contact QPP to discuss further on 07 3013 5555 or encourage the person to self-refer themselves at <a href="https://www.qpp.org.au/self-referral">https://www.qpp.org.au/self-referral</a> .		
<b>New Client Details</b>				
Surname:		First Name:		
Home Phone:		Mobile Phone:		
Home address:				
Email:				
Can a message be left/contact made:		<input type="checkbox"/> By email <input type="checkbox"/> On clients home phone <input type="checkbox"/> On clients mobile phone <input type="checkbox"/> By text to clients mobile phone		
Are there confidentiality concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes-Details:				
Date of Birth: / /		Country of Birth:		
Medicare Eligibility: <input type="checkbox"/> Eligible <input type="checkbox"/> Ineligible		Interpreter required: <input type="checkbox"/> No <input type="checkbox"/> Yes-Language:		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Transgender <input type="checkbox"/> Other		
Client identifies as: <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal & Torres Strait Islander <input type="checkbox"/> Neither				
Does the client have a personal carer? <input type="checkbox"/> No <input type="checkbox"/> Yes-Details:				
<b>Any issues for support identified by the referrer (or other relevant information):</b>				
<input type="checkbox"/> Peer Navigation (for newly diagnosed / HIV health literacy)	<input type="checkbox"/> Peer Group social activities	<input type="checkbox"/> Transport	<input type="checkbox"/> Alcohol & other drugs	
<input type="checkbox"/> Treatment Support (access & adherence)	<input type="checkbox"/> Finances	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Housing	
<input type="checkbox"/> Stigma/Discrimination	<input type="checkbox"/> Legal/Immigration/Visa	<input type="checkbox"/> Employment	<input type="checkbox"/> Dental/Oral Health	
Other relevant information:				
Issues identified by the client being referred:				
<b>Risk Assessment</b>				
Previous physical assault <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, Please specify:		
Previous verbal aggression <input type="checkbox"/> No <input type="checkbox"/> Yes				
History of dangerous weapons use <input type="checkbox"/> No <input type="checkbox"/> Yes				
History of sexual harassment <input type="checkbox"/> No <input type="checkbox"/> Yes				
<b>Confirmation of HIV Status</b> (HIV status can only be confirmed by a client's GP, HIV Specialist, Sexual Health Nurse or POCT)				
I, _____ (your name) confirm that the above named client is HIV positive.				
Signature: _____			Date: / /	
Date of HIV diagnosis / /	Viral Load at last test (optional)	CD4 Count at last test (optional)	Date of last test / /	
For POCT only: Has diagnosis been confirmed? <input type="checkbox"/> Yes-Date: / / <input type="checkbox"/> No <input type="checkbox"/> Pending				