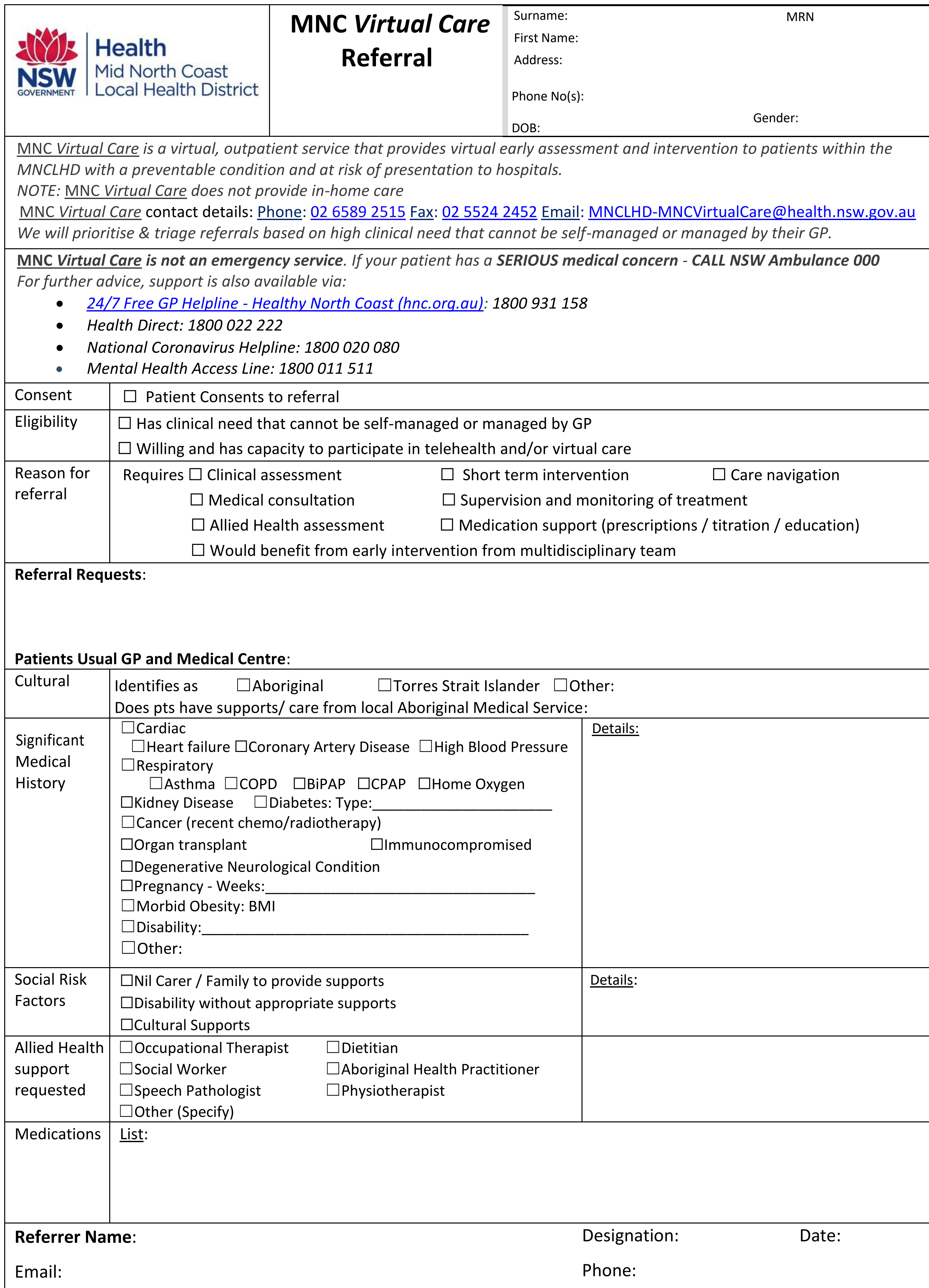

NSW GOVERNMENT Health Mid North Coast Local Health District	**MNC *Virtual Care* Referral**	Surname: First Name: Address: Phone No(s): DOB:	MRN Gender:

MNC Virtual Care is a virtual, outpatient service that provides virtual early assessment and intervention to patients within the MNCLHD with a preventable condition and at risk of presentation to hospitals.
NOTE: MNC Virtual Care does not provide in-home care
MNC *Virtual Care* contact details: Phone: 02 6589 2515 Fax: 02 5524 2452 Email: MNCLHD-MNCVirtualCare@health.nsw.gov.au
We will prioritise & triage referrals based on high clinical need that cannot be self-managed or managed by their GP.

MNC Virtual Care is not an emergency service**. If your patient has a **SERIOUS medical concern - CALL NSW Ambulance 000
For further advice, support is also available via:

- *24/7 Free GP Helpline - Healthy North Coast (hnc.org.au): 1800 931 158*
- *Health Direct: 1800 022 222*
- *National Coronavirus Helpline: 1800 020 080*
- *Mental Health Access Line: 1800 011 511*

Consent	☐ Patient Consents to referral
Eligibility	☐ Has clinical need that cannot be self-managed or managed by GP ☐ Willing and has capacity to participate in telehealth and/or virtual care
Reason for referral	Requires ☐ Clinical assessment ☐ Short term intervention ☐ Care navigation ☐ Medical consultation ☐ Supervision and monitoring of treatment ☐ Allied Health assessment ☐ Medication support (prescriptions / titration / education) ☐ Would benefit from early intervention from multidisciplinary team

Referral Requests:

Patients Usual GP and Medical Centre:

Cultural	Identifies as ☐Aboriginal ☐Torres Strait Islander ☐Other: Does pts have supports/ care from local Aboriginal Medical Service:	
Significant Medical History	☐Cardiac ☐Heart failure ☐Coronary Artery Disease ☐High Blood Pressure ☐Respiratory ☐Asthma ☐COPD ☐BiPAP ☐CPAP ☐Home Oxygen ☐Kidney Disease ☐Diabetes: Type:______________________ ☐Cancer (recent chemo/radiotherapy) ☐Organ transplant ☐Immunocompromised ☐Degenerative Neurological Condition ☐Pregnancy - Weeks:___________________________________ ☐Morbid Obesity: BMI ☐Disability:____ ☐Other:	Details:
Social Risk Factors	☐Nil Carer / Family to provide supports ☐Disability without appropriate supports ☐Cultural Supports	Details:
Allied Health support requested	☐Occupational Therapist ☐Dietitian ☐Social Worker ☐Aboriginal Health Practitioner ☐Speech Pathologist ☐Physiotherapist ☐Other (Specify)	
Medications	List:	

Referrer Name: Designation: Date:

Email: Phone: