

# NBMLHD Community Health Services

## Client Registration & Request for Service Fax Form

Phone **1800 222 608** Between **0900** and **1600** Monday to Friday

Fax **4732 9485** (24 hours)

Complex, Aged & Chronic Care (CACC)  Child & Family Health (C&FH)   
 HealthOne

Title	Last Name	Alias/Previous Name	First Name
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<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Indeterminate	<b>Date of Birth</b> _____	<b>Country of birth</b> _____	<b>Indigenous status (Mandatory (Tick one of the following))</b> <input type="checkbox"/> Identifies as Aboriginal Origin <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Neither A/TSI <input type="checkbox"/> Identifies as Both A & TSI <input type="checkbox"/> Declined to respond <input type="checkbox"/> Unknown
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<b>Address</b> _____ _____ _____ Postcode _____	<b>Telephone</b> Home: _____ Mobile: _____ Work: _____	<b>Preferred Language</b>  <b>Needs Interpreter</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Medicare Card**  Yes  No      **Medicare Card No** \_\_\_\_\_ / \_\_\_\_  
**DVA Card**  Yes  No      **Colour** \_\_\_\_\_ **DVA Card No.** \_\_\_\_\_ **Exp Date** / /

**Current GP/LMO** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Suburb:** \_\_\_\_\_ **P/Code:** \_\_\_\_\_

**Person for Contact:**  
 Last name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_  
**Parent/Guardian Full Name** (for children 0-18yrs) \_\_\_\_\_  
 Phone: \_\_\_\_\_

