



Queensland Government

(Affix MSOH ISOH identification label here)

**Metro South Hospital and Health Service
Metro South Oral Health
Refugee & Asylum Seeker Referral Form**

Client Details:

Client Eligibility Details:

Title: _____ Sex: M F I
 Family name: _____
 Given name(s): _____
 Date of birth: _____ (dd/mm/yyyy)
 Address: _____
 Suburb: _____
 Telephone: _____
 Country of Birth: _____
 Interpreter required: No Yes
 Language spoken: _____
 Other or dialect requirements: _____
 Interpreter preference Female Male No Preference

Does the client go to school?: No Yes → Name of school: _____
 → School year level: _____
 Is the client a Queensland resident: Yes No
 Arrival in Queensland _____ (dd/mm/yyyy)
 Asylum seeker: _____ Refugee: _____
Medicare Card details.
 Medicare Card No: _____
 Reference No: _____ Expiry date: _____ (mm/yy)
Health Care Card or Pension Card details.
 Concession Card No: _____
 Expiry date: _____ (dd/mm/yy)

Preferred Dental Clinic <https://metrosouth.health.qld.gov.au/oral-health/clinics>

Preferred Clinic: _____

Reason for referral (urgent care, dental examination etc. Please give detailed clinical, social reasons, etc.)

Referral From

Name: _____ Position: _____
 Agency: _____ Contact Number: _____
 Signature: _____ Contact Email: _____
 Date: _____

Please FAX referral form to MSOH HUB on (07) 3156 4345

Demographics entered in ISOH
 Placed on Referral Waitlist: Priority 1
 Dental assessment appointment made
 Interpreter booked
 Referral scanned into ECR

Date of appointment: _____

Staff member name: _____

DO NOT WRITE IN THIS BINDING MARGIN

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Oral Health Staff Use Only

METRO SOUTH ORAL HEALTH RAS REFERRAL FORM