



Queensland
Government

(Affix MSOH ISOH identification label here)

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

METRO SOUTH ORAL HEALTH RAS REFERRAL FORM

DO NOT WRITE IN THIS BINDING MARGIN

v1.2 07/2021 (FM008)

Oral Health
Staff Use Only

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: _____
 Is the client a Queensland resident: Yes No
 Arrival in Queensland: _____ (dd/mm/yyyy)
 Asylum seeker: _____ Refugee: _____
 Visa Type: _____
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 email this referral form to MSOH HUB via button on page 2

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: _____

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? Yes No
- Cough
 - Fever
 - Shortness of Breath
 - Sore throat
 - Runny Nose
 - Fatigue
 - Loss of sense of smell or taste
2. Have you travelled interstate or overseas in the last 14 days? Yes No
3. Have you been in contact with a person suspected or confirmed of having COVID-19? Yes No
If yes, date of most recent contact _____
4. Have you been instructed to self- isolate or self-quarantine? Yes No
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Refugees and Asylum seekers requiring Urgent Dental treatment from MSOH

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

- | | | |
|-----------------------|------------------------------|-----------------------------|
| Trauma / Injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling in the face | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling in the mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Uncontrolled bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pain when eating | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Broken Tooth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Broken Denture | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other _____ | | |