



Queensland  
Government

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

To avoid delays in processing, please ensure this form is filled out correctly.

**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?: Name of school:  
→  
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)  
Concession Card No:  
Expiry date: (dd/mm/yy)

**Preferred Dental Clinic**

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:  
Date:

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 NORTH ORAL HEALTH RAS REFERRAL FORM

## COVID screening questions for Refugees and Asylum seekers requesting Emergency Oral health care from MNOHS

1. Are you currently experiencing any of the following?  Yes  No
- Cough
  - Fever
  - Shortness of Breath
  - Sore throat
  - Runny Nose
  - Fatigue
  - Loss of sense of smell or taste
2. Have you tested positive for Covid-19 in the last 14 days?  Yes  No
3. Are you a close contact of a person who has tested positive for COVID-19 in the last 14 days?  Yes  No
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## Refugees and Asylum seekers requiring Urgent Dental treatment from MNOHS

*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 \_\_\_\_\_