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:

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

Client Eligibility Details:

Does the client go to school?: Name of school:

No Yes →

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: Name of Referee / Case Manager / Nurse

Agency: Agency Name

Signature:

Date:

Position:

Contact Number:

Contact Email:

Please email this referral form to MSOH HUB via button on page 2

Oral Health Staff Use Only

- 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:

Clear Form Print form

DO NOT WRITE IN THIS BINDING MARGIN

v1.2 07/2021 (FM008)

METRO SOUTH ORAL HEALTH RAS REFERRAL FORM

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	☐ Yes	☐ No
Swelling in the face	☐ Yes	☐ No
Swelling in the mouth	☐ Yes	☐ No
Uncontrolled bleeding	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Pain when eating	☐ Yes	☐ No
Broken Tooth	☐ Yes	☐ No
Broken Denture	☐ Yes	☐ No

Other _____

Email Referral Form

Clear Form **Print form**