Your Health Navigator (YHN)
Referral form

Member Information

Date of referral *(dd/mm/yyyy)*

Member number

Member name *(first name)* *(surname)*

Member date of birth *(dd/mm/yyyy)*

Address

Postcode

Preferred contact number *(home)* *(mobile)* *(work)*

Email address

Previous YHN client ☐ Yes ■ No

Hospital Admission Information

Date of hospital admission *(dd/mm/yyyy)* ***(ideal call time within 1 week of, or prior to surgery)***

Admitting Hospital Name

Admitting Doctor or Specialist's Name

Expected days in hospital *(if known)*

Surgery type *(if known)*

- ☐ Brain, back, nerve and spine *(Neurosurgery)*
- ☐ Ear, throat and head *(Otolaryngology)*
- ☐ Female reproductive *(Gynaecology)*
- ☐ Joint *(Orthopaedic)*
- ☐ Heart and lung *(Cardiothoracic)*
- ☐ Male reproductive and incontinence *(Urology)*
- ☐ Plastic and reconstructive surgery *(burns, oral, maxillofacial)*
- ☐ Stomach, colon, bowel, etc. *(Gastroenterology)*
- ☐ Other *(please provide details if known)*

Primary reason(s) for referral

- ☐ Previous hospitalisations
- ☐ Surgery type
- ☐ Age
- ☐ Recent fall *(based on conversation)*
- ☐ Home/social situation
- ☐ Hospital admission

Other known information (based on conversation)

How was the call generated? ☐ Inbound *(if so, why did the member call)*

Additional notes