Health
Central Coast
Local Health District

Central Coast Local Health District	*Complete all details*	
COVID 19 Remote Monitoring Referral	**FAMILY NAME:**	
	GIVEN NAME:	
	DATE OF BIRTH:	☐ MALE ☐ FEMALE
Date and Time of Referral:	**ADDRESS:**	
Does the Patient Consent to this Referral: ☐ YES ☐ NO	**Phone Number:**	
	MRN:	**Medicare No:**
Is this referral for a person who is: ☐ **Confirmed COVID, if yes date of positive COVID test:** _____ **Date of onset of symptoms:** _____ ☐ **Close Contact for swabbing** ☐ **Casual Contact for swabbing**	**End date of isolation period:**	
	Date of any repeat swabs required:	
	Can they attend a CCLHD COVID-19 clinic or require home swabs attended?	

Frequency of monitoring requested:
☐ **Daily** ☐ **Twice Daily** ☐ **Other**
If Other, how often is remote monitoring required and reason why:

Emergency Contact/Alternate Contact Name: **Telephone:**
Relationship to Client:

GP Name: **Telephone:**

Details of household members:

Reason for referral (include any current symptoms):

Any known risk factors or other relevant health conditions/information:

COVID Vaccination Status:

☐ **No Vaccination**

☐ **First dose - Date:**

☐ **Second dose – Date:**

Any COVID-19 vaccinations administered to any household members: If yes state type and dates of vaccinations administered:

Referrer Name: **Contact Number:**

Department: **Email:**

How to Refer to the Community COVID Support Team	COVIDCommunitySupportTeam signs and returns by email to PHU once contact has been made:
Phone: 43205092 Email Referral to – CCLHD-COVIDCommunitySupportTeam@health.nsw.gov.au	_____

How to Refer to the Acute Post Acute Care Team

Phone the APAC Nurse Coordinator on: 4320 3482
Fax referral to 4320 3555