The NSW Refugee Health Service offers free health assessments for people who are from a refugee or refugee-like background. A General Practitioner (GP) and a Registered Nurse run these clinics. A Medicare card is not required. Interpreters are booked if needed.

Attendance to these clinics is voluntary. Visits to the clinics will not in any way affect a person’s residency status in Australia. All client information and results are kept confidential.

**Services provided:**

- advice and management of health problems
- simple tests (e.g., blood test, X-rays) as required
- referrals to appropriate health care services

**How to refer:**

- referral can be made by another service provider or
- individuals can refer themselves

**Booking process:**

- Ring **8778-0770** and talk to one of our GP Clinic Nurses, or
- Fax or E-mail a GP Clinic Referral Form (See back for a form)
  - Fax Number: **8778-0790**
  - E-mail Address: SWSLHD-RHSReferrals@health.nsw.gov.au

**What to bring to an appointment:**

- any medications being taken
- any medical records (including records from overseas)
- Medicare card (if a person has one)

**Clinics schedule & Locations:**

- by appointment only

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<thead>
<tr>
<th>AUBURN</th>
<th>BLACKTOWN</th>
<th>LIVERPOOL</th>
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<tbody>
<tr>
<td>Monday</td>
<td>Thursday</td>
<td>Tuesday</td>
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| Auburn Community Health Centre | Blacktown Community Health Centre (Building 1) | NSW Refugee Health Service
| Auburn Hospital   | Corner Marcel Crescent & Blacktown Road | Suite 1, Level 3
| Norval Street     | Blacktown                      | 157-161 George Street, Liverpool       |
| Auburn            |                               |                                        |
REFERRAL FORM
GP Clinic

Client’s Family name: ___________________________ Other Names: _______________________________

Address: _______________________________________________________________________________

Phone no.: _______________ Mobile no.: _______________ D.O.B.: _______________ Sex: _______

Email address: __________________________________________________________________________

C.O.B.: _______________ Languages: ____________________________ Interpreter desired: Yes / No

Local Doctor (if any) & location: ____________________________________________________________ Date of Arrival: ____ / ____ / ____

Humanitarian Program: ☐ Asylum Seeker: ☐ Medicare access yes / no
Has the client ever attended an RHS clinic in the past? YES ☐ NO ☐

Is the client involved with any other agencies and/or receiving immigration support?_____________________

Referred By: ________________________ Organisation: ___________________________________________

Phone: _______________ Fax: _______________ Email: ___________________________________________________________________________________

Is the client aware of this referral? Yes / No – If “No”, please inform the client.

Health problems or issues of concern:
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Please list all family members who will also attend this appointment:

1. Name: __________________________ D.O.B. _________ Issue: _________________________________
   ______________________________________________________________________________________

2. Name: __________________________ D.O.B. _________ Issue: _________________________________
   ______________________________________________________________________________________

3. Name: __________________________ D.O.B. _________ Issue: _________________________________
   ______________________________________________________________________________________

4. Name: __________________________ D.O.B. _________ Issue: _________________________________
   ______________________________________________________________________________________

5. Name: __________________________ D.O.B. _________ Issue: _________________________________
   ______________________________________________________________________________________

Will the client / family be attending your service again? Yes / No