Nursing and Midwifery Health Program
CARING FOR NURSES AND MIDWIVES

Employer Assisted Referral Form

(Employer to complete)

Date: _____

Referring Employer Name: _____

Health Service Name: _____

Phone No: _____

Email Address: _____

Health Service Address: _____

Referred Nurse's Name: _____ _____

Nurse's Position: _____

Nurse's Department: _____

Length of Service: _____

Date of Incident/s: _____

Presenting Issue: _____

_____

_____

Other relevant issues: _____

_____

Preferred Course of Action: _____

_____

_____

Documentation provided to Nurse (attach if appropriate): _____

_____

Release of Information signed by Nurse (attach copy where relevant): ___ YES / ___ NO

Preferred Mode of Communication: ___Email / ___Letter / ___Fax / ___Phone /

___Other (Specify)

Preferred Frequency of Communication: _____

_____