# Medical Referral

This form should be signed by a medical practitioner, occupational therapist, community nurse, community carer, Canberra Blind Society, Aged Care Assessment team member. Please note that individuals with new babies are only eligible for short-term HLS membership.

A phone referral to 6207 5748 from one of the above is also acceptable.

I nominate as a person requiring the services of the Home

Library Service for reason/s listed below.

# Reasons for application (tick one)

## Resident in care facility

## Permanent medical consideration

## Non permanent medical consideration (Must indicate length of time required)

## Permanent full time carer

## Non permanent full time carer (Must indicate length of time required)

## New baby (Optional 3 month or 6 month membership, please specify)

## Other (or specification for above):……...........................................................................

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Signature: ........................................................................................... Date: ........................

Practitioner’s name: ..............................................................................................................

Organisation/occupation: ......................................................................................................

Email: .....................................................................................................................................

Phone (work): ........................................................................................................................

Address: .................................................................................................................................

Suburb: ............................................................................................... Postcode: ................