

COMMUNITY ACCESS REFERRAL FORM for PAC, CBR and HARP

WHAD172



Referral Date / /

Attach Bradma or complete details

Fax referral to 8345 6529 for the following service:

Hospital UR #:.....

Post Acute Care (PAC)

Name:.....

Sunshine Community Based Rehab (CBR)

Address:.....

Williamstown Community Based Rehab (CBR)

Suburb:.....

Postcode:.....Tel:.....

M / F Marital Status:..... D.O.B / /

HARP (circle program) Complex Needs // Diabetes / Cardiac/ Respiratory / Paediatric Asthma

HARP Clinics: Chronic Heart Failure / Diabetes Co- Health/ Diabetes ISIS Primary Care

Exercise Rehab program (circle program): Chronic Heart Failure / Cardiac / Pulmonary

Referrers Name: Position: Tel / Page

Referring Hospital / Agency / Clinic: Unit: Ward:.....

Referred from: Acute Hospital Sub Acute / Rehab / GEM Community Agency Self / carer
 Emergency Hospice / Palliative Care General Practitioner

If client is NOT being discharged to, or currently residing at their usual address, please specify alternative address:
Tel:

Hospital Admission Date: / / Hospital Discharge Date: / / not applicable

Contact Person:..... Tel:

Address: Work:

Relationship Primary carer Yes / No Mobile:

Guardian (if relevant) :..... Tel:

Case Manager: (if relevant)..... Tel:

Agency: Mobile:

GP Name Tel:

Practice Name:..... Fax:

Address:.....

Cultural Information: Aboriginal / Torres Strait Islander Yes / No

Country of Birth: Languages Spoken:

Is interpreter required for: Simple information? Yes / NoComplex / medical information? Yes / No

Religious affiliation: Specific cultural requirements:

Main diagnosis / Reason for admission to hospital :

Other health issues/past medical history.....

Any infectious diseases:.....

Any allergies?

Current medications

(or attach list if available in another format, eg: discharge summary, Medical Director report, etc – not required for post acute care home care referrals)

Goals of Treatment / Expected Outcome of Care.....

Is the patient at risk of re-presenting to hospital? Yes No

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REFERRAL FOR POST ACUTE CARE, CBR and HARP

Social Issues:

Patient Name: UR:

Does the client provide care for others? Specify.....

Accommodation type	Ownership	Lives with	Funding & Pension Status
<input type="checkbox"/> House	<input type="checkbox"/> Owner	<input type="checkbox"/> Lives Alone	<input type="checkbox"/> Pension Type:.....
<input type="checkbox"/> Flat / Unit	<input type="checkbox"/> Private Rental	<input type="checkbox"/> With Spouse / Partner	<input type="checkbox"/> Workcover pending <input type="checkbox"/> approved
<input type="checkbox"/> Boarding House	<input type="checkbox"/> Ministry of Housing	<input type="checkbox"/> With other relatives/ children	Claim #
<input type="checkbox"/> Hostel / SRS	<input type="checkbox"/> Other.	<input type="checkbox"/> With other person.	<input type="checkbox"/> TAC pending <input type="checkbox"/> approved
<input type="checkbox"/> Homeless	Specify:.....	Specify:	Claim #
<input type="checkbox"/> Other.	<input type="checkbox"/> DVA entitlement Card type: White / Gold
.....	Number

Safety / Access Issues - some patients may require either a home visit or treatment in the home. Please specify any issues about the discharge environment that may affect the care or safety of:

- Client / Carer.
- Service Provider

(eg: dogs, firearms, steep or slippery stairs, substance abuse, verbal or physical violence or family conflict)

Can the patient travel in a car? Yes No Does the patient require the front seat ? Yes No
 Is there a reason that rehab must be provided at home? Yes No Reason

Please complete for Post Acute Care, HARP, Community Based Rehab clients (not required for Community TCP):

Client Agreement:

- I (client name) agree:-
- to participate in the Post Acute Care, HARP, and/or Community Based Rehab program and
- that **information about my medical condition and care needs** can be supplied to the staff of these programs and the services providing assistance to me, including my local doctor,
- that the staff may **feed back to the hospital staff** about my recovery and the care needed

SIGNED: (client) DATE:

NON ENGLISH SPEAKING

If English is not my first language I acknowledge that the service has been explained to me with the assistance of an interpreter.

SIGNED: (client) DATE:

CARER / GUARDIAN CONSENT

If the client is unable to give informed consent the guardian or a carer may sign on his/her behalf.

SIGNED: (carer) DATE: RELATIONSHIP:

Nursing and Allied Health Assessments: Hospital staff please fax copies of discharge summaries where relevant. Follow up needed?

Physiotherapy	Name	Tel / Page:	Yes / No
Social Work	Name	Tel / Page:	Yes / No
Dietician	Name	Tel / Page:	Yes / No
Speech Pathology	Name	Tel / Page:	Yes / No
Key Nurse contact	Name	Tel / Page:	Yes / No
Occupational Therapy	Name	Tel / Page:	Yes / No
Other	Name	Tel / Page:	Yes / No

OT Home assessment completed Date of visit ____ / ____ / ____

OT Home assessment pending Date planned ____ / ____ / ____ OT Home assessment not required

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Current Functional status

	Independent	Assisted	Cannot Do	Uses Aids (What?)	Comments and precautions
Mobility					Weight bearing status?
Transfers					
Stairs					
Bathing/Showering					
Dressing					
Toileting – bladder bowels					
Medication					
Shopping					
Meal Preparation					
Eating					
Housework					
Banking/bills					
Transport					

	Normal / No Issue	Impaired / Issues	Comments and precautions
Cognition			
Behaviour			
Mood			
Comprehension			
Communication			
Nutrition			special diet? weight change?
Swallowing			
Vision			glasses?
Hearing			hearing aids?
Skin integrity / wound care			If wound care required, please attach comprehensive information and wound care regime
Pain			Location? Management?
Falls in last 6/12s			Where?

This section is for Services required under Post Acute Care or HARP.

(Please detail **SPECIFIC** service, task or need and suggested frequency) (Examples of some of the available services include: wound care, medication management, home care, health education, personal care, assistance with shopping banking, meal preparation, etc – services are available short term to assist with recovery after a public hospital presentation)

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Other Services - currently in place or newly referred to on discharge.

Service (ie MOW, Home help, Physio, Taxi card))	Agency (ie Council, TAC, DVA, Private Co etc)	Frequency	Existing service in place (tick)	New referral made on discharge (tick)

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