Western Health

Transition Care Program

Referral Form

Bradma

Patient Contacts

Next of Kin: _____

Ph: _____ Mob: _____

Address: _____

Relationship to Patient: _____

Alternate Contact: _____

Ph: _____ Mob: _____

G.P: _____

Ph: _____ Fax: _____

Address: _____

Case Manager: (if applicable)

Name: _____ Agency: _____

Ph: _____ Package Level: _____

Services Requested

☐ **Western Health Bed Based** ☐ **Western Health Community Based**

Reason for Referral: _____

Hospital Admission Date: _____ **Expected Discharge Date:** _____

Reason for Admission: _____

Past Medical History: _____

Referrer Details

Name: _____ **Discipline:** _____ **Ph/Pager:** _____

Referring Hospital: _____ Ward/Unit: _____ Date: _____

Funding Information

Medicare Number: _____ **Pension Type:** _____ **Pension number:** _____

DVA Number: _____ **DVA card colour:** _____

ACAS approval: ☐ Yes ☐ No **ACAS approval for:** _____

Western Health

Bradma

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Social and Cultural Information

Country of Birth: _____ ☐ Aboriginal or Torres Strait Islander

Preferred Language: _____ Interpreter required: ☐ Yes ☐ No

Living Arrangements: ☐ Alone ☐ With Family ☐ With Others ☐ Not stated

Carer Details: ☐ Co-resident carer ☐ Non-resident carer ☐ No carer ☐ Not stated

Accommodation: ☐ Independent living ☐ Supported accom ☐ Residential care ☐ Other

Marrital Status: ☐ Married ☐ Widowed ☐ Defacto ☐ Divorced ☐ Single

Religious/Spiritual Needs: _____

Other relevant social details: _____

_____

Current Functional Status

	Independent	Assisted	Cannot Do	Goals for Transition Care
Medication				
Toileting – Bladder				
Toileting – Bowel				
Bath/Shower/ Dress				
Meal Prep				
Laundry				
Bank/Shopping				
Transport				
Mobility				
Transfers				
Stairs				

Vision / Hearing: _____ Skin Integrity: _____

Cognition: _____

_____

Behavioural/mental health concerns: _____

Precautions / Other: _____

_____

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Services Likely Required for Discharge

Nursing: ☐ Medication ☐ Wound Care ☐ Continence

Case Management ☐

Personal Care ☐

Home Help ☐

Respite ☐

Physio ☐

OT ☐

Speech ☐

Dietetics ☐

Discharge Plan: _____

_____

_____

Other Issues: _____

_____

_____

_____

Barriers to Discharge: _____

_____

_____

_____

- **Please attach any further reports that may assist with the Transition Care Program referral process or discharge plan; ie: Social work and/or Allied Health VCAT reports, VCAT Medical reports, Neuropsychological reports etc.**

- **If you are referring from within the networks of Western Health, Melbourne Health or Northern Health - email all referrals to: WHS - Transition Care Referrals**

- **If you are referring from outside of these three networks, the email address for Western Health Referrals is: TransitionCareReferrals@wh.org.au**