**Referral Form**

|  |  |
| --- | --- |
| Monday to Friday (8:30 am to 5:00 pm)(Excluding public holidays) | Telephone referrals: 1300 769 699Fax referrals: 1300 721 611 |

**PLEASE NOTE: referrals are required to be received by midday where action is required the next business day.**

# Client details

|  |  |  |
| --- | --- | --- |
| Title:       | First Name:       | Surname:       |
| Address:       |
| Suburb:       | Postcode:       | Date of birth:       /       /       |
| Phone:       | Accommodation: own home [ ]  private rental [ ]  public rental [ ]  |
| Client consent obtained: [ ]  | Lives alone: Yes [ ]  No [ ]  | Country of birth:       |
| Language spoken at home:       | Interpreter: Yes [ ]  No [ ]  |
| Aboriginal [ ]  Torres Strait Islander [ ]  Aboriginal and Torres Strait Islander [ ]  not Aboriginal [ ]  |
| Pension type (specify):       |

# Other / second contact / carer details

|  |  |
| --- | --- |
| Name:       | Relationship to client:       |
| Address:       | Phone:       |
| Next of kin details (if different from carer):       |

# Request for services

|  |  |  |
| --- | --- | --- |
| [ ]  Allied health (\*specify below)[ ]  Case management (\*specify below)[ ]  Centre based day support[ ]  Counselling/Information/Advocacy[ ]  Community Nursing Care \*\* | [ ]  Domestic assistance (housework)[ ]  Delivered meals[ ]  Home maintenance (\*specify below)[ ]  Home modifications (\*specify below)[ ]  Personal care (\*specify below; include aids) | [ ]  Respite in home[ ]  Shopping[ ]  Social support (\*specify below)[ ]  Transport[ ]  Other: (\*specify below) |
| \* Specify details (example, Allied Health – Physiotherapy required to assist client after stroke:       |
| [ ]  \*\*Complete if community nursing is required (including clinic):* Is the requested care a continuation of treatment plan of the most recent hospital admission? [ ]  Yes [ ] No
* Was this care being provided prior to admission? [ ]  Yes [ ]  No
* Can the patient be safely discharged without the requested care? [ ]  Yes [ ]  No
* Is it estimated that the care requested will need to be provided for greater than 6 weeks? [ ]  Yes [ ]  No
 |
| Date of 1st visit:       /       /       |
| [ ]  Medication assistance (cannot commence unless drug chart provided) | Drug chart faxed: [ ]  Yes [ ]  No |
| [ ]  Wound care  | Wound chart faxed: [ ]  Yes [ ]  No |
| [ ]  Other (specify):       |
| Discharge address (if different from above):       |

# Current referral details

|  |
| --- |
| Current diagnosis / treatment:       |
| Relevant medical and social history (including current service provider details):       |
| Alerts (cognitive / falls / allergies / home environment):       |

# Referrer and GP details

|  |  |
| --- | --- |
| Referrer name:       | Position:       |
| Organisation:       | Phone:       |
| GP Name:       | Phone:       |
| Address:       | Date:       /       /       |

Thank you for your referral.

**IMPORTANCE NOTICE
The information contained in this document is confidential.
If you receive this message in error, please notify us immediately and return the original message to the sender.**