Tasmanian Community Care
Referral Service

hacc
home and community care

Referral Form

Monday to Friday (8:30 am to 5:00 pm)
(Excluding public holidays)

Telephone referrals: 1300 769 699
Fax 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)	☐ Domestic assistance (housework)	☐ Respite in home
☐ Case management (*specify below)	☐ Delivered meals	☐ Shopping
☐ Centre based day support	☐ Home maintenance (*specify below)	☐ Social support (*specify below)
☐ Counselling/Information/Advocacy	☐ Home modifications (*specify below)	☐ Transport
☐ Community Nursing Care **	☐ Personal care (*specify below; include aids)	☐ 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):

Tasmanian Government

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.