THE ROYAL MELBOURNE HOSPITAL

COMMUNITY SERVICE REFERRAL

SURNAME		URN
GIVEN NAME	DOB	SEX
ADDRESS		
SUBURB	POSTCODE	TELEPHONE

Referral To:

☐ MELBOURNE HEALTH DIRECT ACCESS UNIT
Fax: (0) 8387 2217 Ph: 8387 2333

☐ OTHER: ______

Fax: ______ Ph: ______

DATE: ____/____/______

If patient is not being discharged to above address, please specify:

Address: ______

Suburb: ______ Postcode: ______

Ph: ______ Mob: ______

Referrer Details

Name: ______ Discipline: ______ Ph/Page: ______

Hospital/Agency ☐ RMH ☐ Other: ______ Ward/Unit: ______

Service Requested

☐ **POST ACUTE CARE** ☐ Nursing ☐ Personal care ☐ Home Help ☐ Allied Health ☐ Other: ______

☐ **SUB-ACUTE SPECIALIST CLINICS** ☐ Chronic Wound ☐ Pain Management Services ☐ Continence ☐ Cognitive, Dementia & Memory ☐ Falls & Balance ☐ Young Adult Transition ☐ Medicine

☐ **COMMUNITY THERAPY SERVICE** ☐ PT ☐ OT ☐ SP ☐ SW ☐ Vestibular ☐ Other: ______
Is home-based therapy required? ☐ Yes ☐ No Why? ______
If **No** - how will client access clinic? ☐Drive ☐Family/Friend ☐Taxi ☐ 1/2 price taxi ☐Public Transport ☐Other ______

☐ **HARP – Complex Care (select most appropriate care stream below and attach information as indicated)**
☐ Chronic Heart Failure (Echo Report) ☐ Chronic Respiratory (RFTs for COPD or CT report)
☐ Diabetes Co-Management (HbA1c, other relevant pathology results) ☐ Diabetic Foot Unit
☐ Complex Needs requiring Service Facilitation (current services involved, referrals in place, social history)

PAC, HARP & RDNS Referrals	Attached	Pending	N/A
Discharge Summary	☐	☐	☐
Medication List	☐	☐	☐
Wound Chart	☐	☐	☐
IDC authorisation	☐	☐	☐
Reportable BGL	☐	☐	☐

	Attached	Pending	N/A
Allied Health Referrals AH D/C summary or handover letter	☐	☐	☐
PAC Personal Care Referrals OT or ED CC PC Summary	☐	☐	☐

Reason for Referral *(Nursing Referrals - treatment & Frequency (e.g. wound care three times/week); Allied Health Referrals - Goals of therapy)*

______

______

Hospital Admisson Date: ______ Expected Discharge Date: ______ ☐ N/A (Not inpatient)
☐ *See discharge summary attached* *Include dates where applicable*

Diagnosis / Reason for Hospital Admisson:

______

______

Relevant Past Medical History______
Include chronic conditions & mental health

______

______

Funding Information

Medicare Number
If not on Bradma ______

Pension Type ______ Number ______

☐ TAC Number ______
☐ DVA ☐ Gold Card Number ______
☐ Workcover Number ______

Patient Contacts

Next of Kin / contact: ______
Ph: ______ Mob: ______
Address: ______
Relationship to Patient: ______ ☐ Primary Carer

GP: ______
Ph: ______ Fax: ______
Address: ______

Alternative contact: ______
Ph: ______ Mob: ______
Address: ______
Relationship to Patient: ______ ☐ Primary Carer

Case Manager *if applicable*
______
Ph: ______
Agency: ______

COMMUNITY SERVICE REFERRAL

IP80/OP80

ITEM: 42393.24 CR: 08/16 VER: 11/16

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COMMUNITY SERVICE REFERRAL

SURNAME		URN
GIVEN NAME	DOB	SEX
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SUBURB POSTCODE		TELEPHONE

Social & Cultural Information

Country of Birth: ____________________ ☐ Aboriginal or Torres Strait Islander

Preferred Language/s: ____________________ Interpreter Required for: ☐ Simple information ☐ Complex Information

Marital Status	Living arrangements	Carer Details	Accomodation
☐ Married	☐ Alone	☐ Co-resident carer	☐ Independent Living
☐ Widowed	☐ With family	☐ Non-Resident carer	☐ Supported Accomodation
☐ Defacto	☐ With Others	☐ No Carer	☐ Residential Care
☐ Divorced	☐ Not Stated	☐ Not Stated	☐ Short term crisis or transitional
☐ Single			☐ Homeless or none
☐ Not Stated			☐ Not Stated

Any other information regarding social circumstances that may impact on what & how community care is delivered.
e.g. availability of family support

____

____

Risk Assessment

Clinical ☐ At risk of hospital admission ☐ Carer Stress ☐ At risk of falls

Home Visit Safety ☐ Not applicable - Referrer aware of no potential safety concerns ☐ Home visit not required

Specify if you are aware of any issues that may impact on patient, carer or service provider safety in the home environment.
e.g. history of aggressive behaviour by patient, family member, neighbour, presence of pets or firearms.
Please attach home visit risk screen if available

____

____

Other Services

Was the patient recieving any services prior to admission &/or have referrals been made to services not already mentioned?
If referring for PAC please consider patient's care plan beyond the initial period of service provided by PAC (i.e. 28 days or 7 nursing visits).

☐ Not Applicable - No other services involved or referrals required

Service *e.g. MOW, physiotherapy*	**Agency** *e.g. My Aged Care (for council, community and ACAS services)*	**New Referral**	**Pre-Existing**
		☐	☐
		☐	☐
		☐	☐

Allied Health

If patient has been assessed by Physiotherapy, OT, speech, Dietician, Social work or other allied health please provide contact details.

☐ Not Applicable - Patient is independent & self caring

Name __________ Discipline __________ Tel/Page __________

Name __________ Discipline __________ Tel/Page __________

Name __________ Discipline __________ Tel/Page __________

OT Home Visit ☐ Not Required ☐ Pending ☐ Completed Date (*if applicable)* __________

Client Agreement

I, ______________________________ *(patient name)* agree*:*

- To participate in ______________________________ *(state service/s referred for)*,
- That information about my medical condition and care needs can be supplied to the staff of this program and may be discussed with services providing assistance to me, my local doctor and referring hospital staff when appropriate
- That where English is not my first language, I acknowledge that this referral has been explained to me with the assistance of a qualified interpreter.

Signed __________ Date __________

If the client is unable to give informed consent, a carer may sign on his/her behalf:

Signed __________ Date __________

Name __________ Relationship to patient __________

☐ **Verbal consent gained** Consent gained by (Clinician name): __________

Designation __________ Date __________