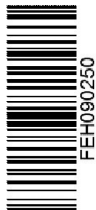

easternhealth

AMBULATORY CARE AND COMMUNITY SERVICES REFERRAL FORM

Type or write legibly in black pen

UR Number: ______
Surname: ______
Given Name: ______
Address: ______
Date of Birth: ____/____/____ Sex: ☐ M ☐ F
Affix Hospital ID Label If Available – Internal use

Do NOT use this form to refer to ACAS, Aged Persons Mental Health, Transition Care Program, Residential-In-Reach or Community Health.
Community Access Unit – ph. 9881 1100
Send this form by fax: 9881 1102 or email: sacs.integratedcare@easternhealth.org.au

Referrer's name: ______ Designation: ______
Location/Organisation: ______
Email: ______ Phone No: ______
Referral Date: ______ Est. Discharge Date: ______

Reason for Referral

Presenting problem or diagnosis and the impact on the client? What does the client need?

Client Information

Surname: ______ Given Name: ______

Sex: Male ☐ Female ☐ Other ☐ D.O.B: / / Confirmed Yes ☐ No ☐

Mobile Number: ______ Phone Number: ______

Medicare Number: __ __ __ __ __ __ __ __ __ (__)

Is this a claim for: TAC ☐ VWA ☐ DVA ☐ Reference No.: ______

Does the client have an NDIS-Approved plan? Yes ☐ No ☐

Does client identify as being of ATSI origin? Yes ☐ No ☐

If yes: does the client agree to a referral to Eastern Health Aboriginal Services? Yes ☐ No ☐

If unknown: Question unable to be asked ☐ or Client refused to answer ☐

Does the client have?
No advance care directive ☐
Presence of an advance care directive ☐
Presence of a medical treatment decision maker ☐
Presence of both an advance care directive alert and a medical treatment decision maker ☐

Interpreter required: Yes ☐ No ☐ If yes, preferred language: ______

Client's Country of Birth: ______

Client's living arrangement: With family ☐ With Others ☐ Alone ☐

Usual accommodation: Independent ☐ Aged Care Residential ☐ SRS ☐ Other ☐ ______

Client's usual address: ______

Client's temporary address: (or NA ☐) ______

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AMBULATORY CARE AND COMMUNITY SERVICES REFERRAL FORM

Type or write legibly in black pen

UR Number: ______________________

Surname: ______________________

Given Name: ______________________

Address: ______________________

____

Date of Birth: _______/_______/_______ Sex: ☐ M ☐ F

Affix Hospital ID Label If Available – Internal use

Client Information

Name of carer(s) or NOK: ______________________

Carer(s)/NOK Phones: Ph: ______________ Mobile: ______________

To make appointment contact: Client ☐ or Carer(s)/NOK ☐

Carer(s)/NOK availability Yes ☐ No ☐

Carer residency status: Co-Resident ☐ Non-resident ☐

GP Name: ______________ GP Phone: ______________

GP Address: ______________________

Medical Information

Relevant history, medications or specialists: Home Oxygen ☐

(i) Additional Medical History: Attached ☐ (ii) Additional Current Medications: Attached ☐

Social and Community

Include current community services and relevant social situation.

Other concurrent referrals:

Client risks: Falls ☐ Pressure Care ☐ Medication ☐ Allergies ☐ Living/Carer Situation ☐

Cognition ☐ Malnutrition ☐ Likely to present to hospital ☐ Nil identified ☐

Other ☐ ______________________

Strategies to manage risk:

Staff risks: Violence ☐ Behaviour ☐ Home Visit risk ☐ Drug & Alcohol ☐ Hoarding ☐

Squalor ☐ Nil identified ☐ Other ☐ ______________________

Client is aware of referral and consents to receive requested service(s): Yes ☐ No ☐

If no, provide details:

Client consents to sharing of relevant information as required Yes ☐ No ☐

Client consents to receive information electronically (inc. SMS) Yes ☐ No ☐

Client signature (if appropriate) ______________________

Referrer's signature ______________________ Date: / /

AMBULATORY CARE AND COMMUNITY SERVICES REFERRAL FORM

EH090250

easternhealth

AMBULATORY CARE AND COMMUNITY SERVICES REFERRAL FORM

Type or write legibly in black pen

UR Number: ______________________

Surname: ______________________

Given Name: ______________________

Address: ______________________

____

Date of Birth: ____/____/____ Sex: ☐ M ☐ F

Affix Hospital ID Label If Available – Internal use

Rehabilitation

☐ Community Rehabilitation Program

Client has experienced a change in function due to a recent acute medical/health event and requires goal-directed rehabilitation.

Indicate profession(s) requested (req).

Discharge (DC) Summary is required and should be attached

	Req.	DC sum.
Occupational Therapy	☐	☐
Physiotherapy	☐	☐

- *If physio-only is required within 7 days of discharge to prevent hospital readmission, contact Post Acute Care (PAC).*

	Req.	DC sum.
Neuropsychology	☐	☐
Social Work	☐	☐
Dietetics	☐	☐
Speech Pathology	☐	☐
Rehabilitation Medicine	☐	☐

Client would benefit from therapy in the following setting:

Centre-based ☐

Home-based ☐

(Please justify) ______________________

____

Chronic Disease Management

☐ HARP (Hospital Admission Risk Program)

Client has a chronic health condition and/or psychosocial complexity and requires care coordination to prevent hospital presentation. Client or carer has potential to manage health conditions.

- ☐ Cardiac
- ☐ Diabetes
- ☐ Psychosocial
- ☐ Respiratory
- ☐ Chronic Complex

☐ Cardiac Rehabilitation

To assist people with cardiac conditions to return to an active and fulfilling life.

☐ Heart Failure Rehabilitation

To assist people with heart failure improve their knowledge and level of functions

☐ Pulmonary Rehabilitation

To improve the strength and exercise tolerance of people suffering from a chronic respiratory conditions

☐ Oncology Rehabilitation

To assist people with a primary diagnosis of cancer achieve their maximum level of function

Specialist Clinics

☐ Continence Clinic

Client requires assessment and management by geriatrician and/or physio and/or nursing to address incontinence. Must be over 16 years old.

☐ Falls and Balance Clinic

Client requires geriatrician PLUS physiotherapy & occupational therapy assessment to determine cause of falls/poor balance and to recommend falls prevention strategies.

☐ CDAMS Cognitive Dementia and Memory Service

Client requires comprehensive multidisciplinary assessment to determine new diagnosis of possible/early dementia or related conditions.

☐ Complex Care Clinic

Client requires geriatrician assessment of multiple aged related medical conditions and/or requires diagnosis of cognitive changes which have progressed beyond early stages.

☐ Movement Disorders Program

Client has a diagnosis of Parkinson's Disease or Parkinsonian Disorder and requires multidisciplinary strategy training and/or review by Neurologist and/or Clinical Nurse Consultant.

☐ Ambulatory Pain Management Service

Client is ready to participate in active self-management of chronic non-malignant pain including medication management and allied health programs. Active TAC or WorkCover client are ineligible. Client is aware that attendance at group Service Orientation Session is required in most cases in order to access the service

Intensive Home-based Evaluation and Management

☐ Geriatric Evaluation and Management at Home (GEM@Home)

Short-term intensive intervention.

Client requires home-based geriatrician PLUS nursing or allied health evaluation, diagnosis, management and treatment.

Client is ageing with complex medical and functional needs.

Client has restorative goals.

☐ Rapid Outreach Response (ROR)

Medium-term intervention.

Rapid response for older persons with high level complex social or functional issues.

Development of relationship with the older person to enable acceptance of required interventions and assistance.

Completion of an urgent ACAS assessment.