easternhealth
GREAT HEALTH AND WELLBEING

# ambulatory care and community services referral form

**Write legibly in black pen.**

Client name: _____

Community Access Unit – ph. 9881 1100

Send this form by:

f. 9881 1102

e. sacs.integratedcare@easternhealth.org.au

**Do NOT use this form to refer to ACAS, Aged Persons Mental Health, Transition Care Program, or Community Health.**

| | | | |
|---|---|---|---|
| Referrer's name: | | | |
| Location / Organisation: | | | |
| Email: | | Phone: | |
| Date of referral: | / / | Designation: | |

**Reason for Referral**

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

**Client Information**

| | | | |
|---|---|---|---|
| Surname: | | Given: | |
| Sex: | ☐ M ☐ F ☐ X | D.O.B: | / / |
| Mobile: | | Phone: | |
| Medicare: | ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (___) | | |
| ☐ TAC ☐ VWA ☐ DVA | Ref # | | |
| Does client identify as being of **ATSI** origin? | ☐ Yes ☐ No ☐ Unknown | | |
| *If yes*: does client agree to referral to Eastern Health Aboriginal Services? | ☐ Yes ☐ No | | |
| *If unknown*: | ☐ Question unable to be asked *or* ☐ Client refused to answer | | |
| Does the patient have an Advance Care Plan, Enduring Power of Attorney? | ☐ Yes (attach) ☐ No | | |
| Interpreter required: | ☐ Yes ☐ No | If yes, preferred langauge: | |
| Client country of birth: | | Confirmed client DOB: | ☐ Yes ☐ No |
| Living arrangement: | ☐ With Family ☐ With Others ☐ Alone | | |
| Client usual accommodation: | ☐ Independent ☐ Aged Care Residential ☐ Supported Residential Service ☐ Other_____ | | |
| Client usual address: | | | |
| Client temporary address: (or ☐ N/A ) | | | |

*Client Information continued over page*

ambulatory care and community services referral form EH090250

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FEH090250

## Client Information (continued)

| | | | |
|---|---|---|---|
| Client carer availablity: | ☐ Yes ☐ No | Carer residency status: | ☐ Co-resident ☐ Non-resident |
| Name of carer(s) or NOK: | | Relationship: | |
| Carer / NOK phone contact: | Ph: | Mobile: | |
| To make appointment contact: | ☐ Client ☐ Carer / NOK | | |
| Is client in hospital/HITH: | ☐ Yes ☐ No | Estimated discharge date: | / / |
| GP name: | | GP phone: | |
| GP address: | | | |

## Relevant Medical Information

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<br>☐ Cognition ☐ Malnutrition ☐ Likely to present to hospital ☐ Nil identified<br>☐ Other_____ |
| Strategies to manage risk: | |
| Staff risks: | ☐ Violence ☐ Behaviour ☐ Home Visit ☐ Drug & Alcohol ☐ Hoarding ☐ Squalor<br>☐ Nil identified<br>☐ Other_____ |

| | |
|---|---|
| Client is aware of referral and consents to receive service(s) | ☐ Yes ☐ No |
| *If no*, provide details: | |
| Client consents to sharing of relevant information | ☐ Yes ☐ No |
| Client consents to receive information electronically | ☐ Yes Email address: _____ ☐ No |
| Client signature: (if appropriate) | |
| Referrer's signature: | |
| Date: | / / |

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## SERVICE REQUESTED

Community Access Unit may redirect referral based on client need

### 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 Summary Attached |
|---|---|---|
| Occupational Therapy | ☐ | ☐ |
| Physiotherapy | ☐ | ☐ |
| Neuropsychology | ☐ | ☐ |
| Social Work | ☐ | ☐ |
| Dietetics | ☐ | ☐ |
| Speech Pathology | ☐ | ☐ |
| Rehabilitation Medicine | ☐ | ☐ |

### 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 condition.*

- ☐ Chronic Complex - chronic medical conditions
- ☐ Psychosocial
- ☐ Cardiac
- ☐ Diabetes
- ☐ Respiratory

☐ **Cardiac rehabilitation**

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

☐ **Heart failure rehabilitation**

*To assist people with heart failure improve their knowledge and level of function.*

☐ **Pulmonary rehabilitation**

*To improve the strength and exercise tolerance of people suffering from a chronic respiratory condition.*

☐ **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 stage.*

☐ **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. GP referral preferred.*
***Note:** Active TAC and Work-cover clients are ineligible.*

### 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.*

Total number of pages in referral including attachments: _____

Referrer Name: _____ Signature: _____

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