

## 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, GEM@Home or Community Health.

Community Access Unit – ph. 9881 1100

Send this form by fax: 9881 1102 or email: [sacs.integratedcare@easternhealth.org.au](mailto: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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### 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  Infection Risk:

Weight-bearing Status: \_\_\_\_\_

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

### Social and Community

Include current community services and relevant social situation.

Does the client have a Home Care Package? Yes  No  Level: \_\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_



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### 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	<input type="checkbox"/>	<input type="checkbox"/>

Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>
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• *Priority Referral (likely to deteriorate and/or be readmitted if not seen within 7 days). Please justify \_\_\_\_\_*

Neuropsychology	<input type="checkbox"/>	<input type="checkbox"/>
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Social Work	<input type="checkbox"/>	<input type="checkbox"/>
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Dietetics	<input type="checkbox"/>	<input type="checkbox"/>
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Speech Pathology	<input type="checkbox"/>	<input type="checkbox"/>
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Client would benefit from therapy in the following setting:

Centre-based	<input type="checkbox"/>
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Home-based	<input type="checkbox"/>
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(Please justify) \_\_\_\_\_

**Focal Spasticity Management Clinic**

*Provides comprehensive medical assessment and recommendations regarding the management of focal spasticity. Follow-up allied health interventions are not organised in the clinic.*

### 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*

**Rehabilitation Medicine**

*Rehabilitation Medicine is the medical specialty concerned with the diagnosis, evaluation and treatment of patients with limited function as a consequence of disease, injury, impairment and/or disability.*

### Intensive Home-based Evaluation and Management

**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.*