easternhealth

Intra-HIP Handover Form

Please type or use black pen.

UR Number: _____

Surname: _____

Given Name: _____

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

Affix Hospital ID Label If Available

FEH090300

Referred by (name & service): _____

Referred to (name & service): _____ **Date referred:** _____

Is an interpreter required? ☐ Yes ☐ No Language spoken:

Can client be contacted to make appointment? ☐ Yes ☐ No

If not, who should be contacted? Name: _____ Relationship: _____

Best contact number: _____

Has the patient had any of the following?

A) Multiple admissions in the past 12 months ☐ Yes ☐ No

B) Frequent presentations for the same issue ☐ Yes ☐ No

Presenting Diagnosis:

Past Medical History:

Social and community *(include current community services and relevant social situation):*

Other concurrent referrals:

Client risks: ☐ Falls ☐ Pressure care ☐ Living/carer situation ☐ Medical allergies
☐ Cognition ☐ Malnutrition ☐ Likely to present to hospital ☐ Nil Identified

Staff risks: ☐ Violence ☐ Behaviour ☐ Home visit risk ☐ Drug & Alcohol
☐ Hoarding ☐ Squalor ☐ Nil identified ☐ Other

Strategies to manage risk: Home Visit Risk Completed ☐ Yes ☐ No
EMR Alert Completed ☐ Yes ☐ No

Home visit considerations *(include home situation, others in house, risk of violence)*:

Plan and assessment *(current issues affecting client's functioning e.g. mobility, continence, medications, nutrition, mood, cognition, communication, ADLs, carer involvement)*

Reason for request and level of priority:

☐ Remains with referring service Date discharged from service: _____

Signature: _____ Name *(please print)*: _____ Designation: _____ Date: __/__/__

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Instructions on how to facilitate an Intra-Health Independence Program referral

Patient identified as requiring an Intra-HIP referral

↓

Phone call made to Coordinator/Team Leader of receiving program to discuss referral

↓

Referral accepted?

← Yes

→ No

Referrer:

- ☐ Completes Intra-HIP Handover Form
- ☐ Form emailed or faxed to receiving program and is sent for priority scanning
- ☐ Ensures Home Visit Risk Assessment is completed in CPF
- ☐ Referring admin registers client in HMS waitlist (not required for GEM@Home or PAC)
- ☐ Documents in CPF referral acceptance and other pertinent clinical information

Receiving program:

- ☐ Completes usual administration tasks e.g accepts patient off waitlist, opens CPF episode etc

Referrer discusses other referral options with their Team Leader

CONTACT DETAILS				
CRP	**Angliss** Ph: 9764 6229 crpintakeah@ easternhealth.org.au	**PJC** Ph: 9881 1842 crpintakepjc@ easternhealth.org.au	**WH** Ph: 9955 1227 crpintakewh@ easternhealthorg.au	**YRH** Ph: 8706 9696 crpintakeyrh@ easternhealth.org.au
Specialist clinics	**Angliss** Fax: 9764 6330 Ph: 9764 6229	**PJC** Fax: 9881 2439 Ph: 9881 1842	**WH** Fax: 9955 1388 Ph: 9955 1227	**YRH** Fax: 9091 8899 Ph: 8706 9696
HARP	Central ph: 9955 7501 Who will direct your call to triage of the day harp.help@easternhealth.org.au			
PAC	For site contact details – please see intranet: Click here			
GEM@Home	Ph: 0439 688 028 gemathome@easternhealth.org.au			

Signature: _____ Name *(please print)*: _____ Designation: _____ Date: __/__/__

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