FEH090250

eastern**health**

AMBULATORY CARE AND COMMUNITY SERVICES REFERRAL FORM

Type or write legibly in black pen

UR Number: _____

Surname: _____

Given Name: _____

Address: _____

Phone No. _____ D.O.B: / / Sex: ☐ M ☐ F

Affix Hospital ID Label If Available – Internal use

Do NOT use this form to refer to ACAS, Aged Person Mental Health, Community Health, GEM@Home, HARP, Residential Inreach, or Transition Care Program.
Send completed form to Eastern Health's Community Access Unit via fax: 9881 1102
or email: sacs.integratedcare@easternhealth.org.au or phone enquiries to: 9881 1100

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: _____ (__) Valid To: /

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	☐	☐
Physiotherapy	☐	☐

Priority Referral (likely to deteriorate and/or be readmitted if not seen within 7 days). Please justify

Neuropsychology	☐	☐
Social Work	☐	☐
Dietetics	☐	☐
Speech Pathology	☐	☐

Client would benefit from therapy in the following setting:

Centre-based ☐

Home-based ☐

(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

☐ 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

SACS Specialist Clinics

GP referral or endorsement required

☐ Continence Clinic

Client requires assessment and management by doctor 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 diagnose 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.