easternhealth

Ambulatory Care and Community Services - Referral Form Instructions

Instructions for referring

Reason for referral: Complete what your client's main presenting problem is. Comment on how the problem impacts on function (eg mobility, self care, cognition, safety, pain), why you are referring and what is needed to improve the problem? Be specific and identify need clearly.

Client information: This data is essential for reporting to Department of Health and Human Services as well as for efficient referral processing. If information is incorrect or missing it may impact on whether the client accesses the required service in a timely way. Often a client has changed GP. Essential correspondence may not get to the GP without you confirming details. The referral may be returned to you with a request to complete all information.

Service requested: There are several ambulatory care and community services. In some cases the Community Access Unit may redirect your referral to a service best suited to need.

A summary of services is provided here:

Service	Details	Requirements
Rehabilitation		
Community Rehabilitation Program	Client has experienced a change in function due to a recent acute medical/health event and requires goal-directed rehabilitation. If physio-only is required within 7 days of discharge, contact Post Acute Care (PAC). Home-based therapy requires justification.	Discharge summary for requested discipline(s) or indicate location in CPF (episode/tab and page number).
Early Supported Discharge (Stroke)	Client requires intensive stroke rehabilitation Referrals will be accepted from Eastern Health acute and sub-acute wards only.	Notify ESD coordinator. Provide: Home Visit Risk Screen, Consent Form, Medical Referral.
Specialist Clinics		
Continence Clinic	Client requires assessment and management by medical and/or physio and/or nursing to address incontinence. Is over 16 years.	GP health summary, relevant investigations and medication list helpful.
Falls and Balance Clinic	Client requires geriatrician PLUS physiotherapy & occupational therapy assessment to determine cause of falls/poor balance and recommendation re falls prevention strategies.	GP health summary, relevant investigations and medication list helpful.
Cognitive Dementia and Memory Service-CDAMS	Client requires comprehensive multidisciplinary assessment to determine new diagnosis of possible/early dementia or related conditions. For inpatients, consider request for GP to refer to be included in EH discharge summary.	GP health summary and medication. Prior to first appointment, GP dementia screen required, ie CT brain, bloods and MMSE.
Complex Care Clinic	Client requires geriatrician assessment of multiple age related medical conditions and/or requires diagnosis of cognitive changes which have progressed beyond early stage.	GP health summary and medication list helpful. If memory for investigation, dementia screen, ie CT brain, bloods and MMSE required prior to first appointment.
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. For diagnosis: refer to Movement Disorder Diagnostic Clinic, Box Hill Hospital	

	Outpatients.	
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 Work-cover clients are ineligible.	Client is aware that attendance at group Service Orientation Session is required in most cases in order to access the service.
Chronic Disease Management		
Hospital Admission Risk Program (HARP) -Cardiac -Diabetes -Psychosocial -Respiratory -Chronic Complex	Aims to prevent avoidable hospital presentations and admissions by working with those clients at risk of, or already experiencing frequent emergency presentations or hospital admissions. Targets people with chronic disease, aged and/or complex needs who frequently use hospitals or are at imminent risk of hospitalisation and could benefit from coordinated care. Works in collaboration with other acute, community, aged care and specialist services to provide alternative interventions to hospital admission where appropriate. Referrers external to Eastern Health: include relevant/available medical information ie medication list, health summary and recent medical discharge summary. For HARP Cardiac, a recent Echocardiogram is required.	
Cardiac Rehabilitation Group	A multidisciplinary 5 week day program and a 4 week evening program with 1 hour exercise and 1 hour education for all programs. Is designed to assist people with cardiac conditions return to an active and fulfilling life. Use ambulatory care and community services referral form or https://www.easternhealth.org.au/images/services/cardiacrehabeh_025400.pdf	
Heart failure Rehabilitation Group	An 8 week multidisciplinary education and exercise program tailored to the individual client to improve exercise tolerance and help the client understand and manage their heart failure symptoms. Use ambulatory care and community services referral form or https://www.easternhealth.org.au/images/services/cardiacrehabeh_025400.pdf	
Pulmonary Rehabilitation Group	A multidisciplinary 12 week exercise and education program designed to improve the strength and exercise tolerance of people suffering from a chronic respiratory condition.	
Oncology Rehabilitation Group	A multidisciplinary 7 week exercise and education program designed to assist people with a primary diagnosis of cancer achieve their maximum level of function.	
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 aging with complex medical and functional needs. Client has restorative goals.	GP requirements- Health summary Current medications Recent relevant investigations
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.	

Do not use this form for:	
Aged Care Assessment Service (ACAS)	http://www.myagedcare.gov.au/
Aged Persons Mental Health Service (APMHS)	Ph. 1300 721 927
Eastern Health - Community Health	Ph. 1300 130 381 https://www.easternhealth.org.au/services/item/200-community-health
Residential In Reach	Ph. 9955 7474
Transition Care Program (TCP)	Ph. (03) 9955 7585