



**Peter James Centre**  
Member of Eastern Health

**Eastern Post Acute Care Programme  
REFERRAL TOOL**

UR Number: .....

Surname: .....

Given Name: .....

Date of Birth: / / Sex: M / F

(Affix Hospital I.D. Label if Available)

Telephone Number: ..... (Patients contact number must always be supplied)

<b>Admission Date:</b> .....	<b>Expected Discharge Date:</b> .....	<b>Referral Date:</b> .....	<b>Ward: &amp; Unit:</b> .....
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**Referred By:** ..... Position/Designation .....  
..... Contact Phone No.: .....  
Sign and print name above ..... Contact Fax No.: .....

Referral From:  Acute Hospital  Sub Acut/Rehab/GEM  Community  
 Emergency  Hospice/Palliative

Is the client discharge address different from the Patient ID Label? Yes / No – if yes give details

**Client demographics:**  
Aboriginal and/or Torres Strait Islander? Yes / No Country of Birth: .....  
Religious Affiliation: ..... Language Spoken: .....  
Specific Cultural Requirements: ..... Is Interpreter required for: Simple  
Complex Medical Information

**1st Contact:** Name: ..... Telephone: .....  
Address: ..... Work: .....  
Relationship Primary Carer: Yes / No Mobile: .....

**2nd Contact:** Name: ..... Telephone: .....  
Address: ..... Work: .....  
Relationship Primary Carer: Yes / No Mobile: .....

**Usual Living Arrangements:**  
 House  Flat / Unit  Boarding House  Hostel / SRS  Other: Specify.....  
 Lives Alone  With spouse / partner / relative  With other person

<b>Reason for client admission to hospital and diagnosis:</b> (Include pre-morbid condition)	<b>Social and other health issues:</b> (Include carer responsibilities)
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**GP Name:** ..... Telephone: .....  
**Address:** ..... Fax: .....

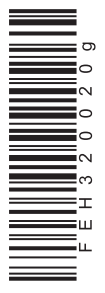
<b>Funding &amp; Pension Status</b> <input type="checkbox"/> Pension Type: ..... <input type="checkbox"/> Workcover Pending <input type="checkbox"/> TAC Pending <input type="checkbox"/> DVA No:.....	<b>Safety/Access Issues:</b> Specify any issues about the discharge environment that may affect the care or safety of <input type="checkbox"/> Client ..... <input type="checkbox"/> Carer ..... <input type="checkbox"/> Service Provider .....
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**Pre-existing services:**

Service Type	Service Provider	Frequency
<input type="checkbox"/> Nursing	.....	.....
<input type="checkbox"/> Personal Care	.....	.....
<input type="checkbox"/> Home Care	.....	.....
<input type="checkbox"/> Delivered Meals	.....	.....
<input type="checkbox"/> Allied Health	.....	.....

Case Manager (name): ..... Agency ..... Telephone:.....  
Available Family Assistance: .....

**ONCE YOU HAVE COMPLETED PAGES A & B OF THIS REFERRAL, PLEASE CONTACT  
THE PAC CLINICAL CO-ORDINATOR ON EXT. 815**



EH 3 2 0 0 2 0 9

FSG Print Management Tel: 9873 5144 Fax: 9873 5966

**EASTERN POST ACUTE CARE PROGRAMME - REFERRAL TOOL**  
**EH 320020**



**Peter James Centre**  
Member of Eastern Health

**Eastern Post Acute Care Programme  
REFERRAL TOOL**

UR Number: \_\_\_\_\_

Surname: \_\_\_\_\_

Given Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M / F

(Affix Hospital I.D. Label if Available)

Physical & Mental Status at Discharge	Please circle	Comments:
Cognitive function	<i>Normal/Impaired</i>	
Behaviour/Mood	<i>Normal/Impaired</i>	
Vision	<i>Normal/Impaired</i>	
Hearing	<i>Normal/Impaired</i>	
Nutrition	<i>Normal/Impaired</i>	
Swallowing	<i>Normal/Impaired</i>	
Communication	<i>Normal/Impaired</i>	
Bowel	<i>Normal/Impaired</i>	
Bladder	<i>Normal/Impaired</i>	
Skin Integrity	<i>Normal/Impaired</i>	
Mobility	<i>Normal/Impaired/Requires Assistance/NWB - Comments:</i>	

Activities of Daily Living (predicted ability on discharge)	Please circle	Support available?	Support Required?	Please specify supports in place or other issues
Bathing/Showering	<i>Independent/Assisted/Dependent</i>			
Dressing/Undressing	<i>Independent/Assisted/Dependent</i>			
Preparing Meals	<i>Independent/Assisted/Dependent</i>			
Grooming	<i>Independent/Assisted/Dependent</i>			
Transferring	<i>Independent/Assisted/Dependent</i>			
Toileting	<i>Independent/Assisted/Dependent</i>			
Footcare	<i>Independent/Assisted/Dependent</i>			
Shopping	<i>Independent/Assisted/Dependent</i>			
Banking	<i>Independent/Assisted/Dependent</i>			
Housework	<i>Independent/Assisted/Dependent</i>			
Home Maintenance	<i>Independent/Assisted/Dependent</i>			
Transport	<i>Independent/Assisted/Dependent</i>			
Medication Manag.	<i>Independent/Assisted/Dependent</i>			
Wound Care	<i>Independent/Assisted/Dependent</i>			
Other (specify)	<i>Independent/Assisted/Dependent</i>			
Other Referrals Made				

Referral discussed with client/family/care manager: **Yes / No** (Specify Who)

Please indicate what new or additional services will be required under the PAC Program:

Service: Task: Frequency:

Service: Task: Frequency:

Service: Task: Frequency:

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