FEH320020g

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)

Admission Date:	**Expected Discharge Date:**	**Referral Date:**	**Ward: & Unit:**

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 diffent from the Patient ID Label? Yes / No – if yes give details

Client demographics:

Aboriginal and/or Torres Strait Islander? Yes / No

Religious Affiliation: .....

Specific Cultural Requirements: .....

Country of Birth: .....

Language Spoken: .....

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

Reason for client admission to hospital and diagnosis:	**Social and other health issues:**
(Include pre-morbid condition)	***(Include carer responsibilities)***

GP Name: ..... Telephone: .....

Address: ..... Fax: .....

.....

Funding & Pension Status

☐ Pension Type: .....
☐ Workcover Pending
☐ TAC Pending
☐ DVA No:.....

Safety/Access Issues: Specify any issues about the discharge environment that may affect the care or safety of

☐ Client .....
☐ Carer .....
☐ Service Provider .....
.....

Pre-existing services:

Service Type	Service Provider	Frequency
☐ Nursing	.....	.....
☐ Personal Care	.....	.....
☐ Home Care	.....	.....
☐ Delivered Meals	.....	.....
☐ 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

FSG Print Management Tel: 9873 5144 Fax: 9873 5966

EASTERN POST ACUTE CARE PROGRAMME – REFERRAL TOOL

EH 320020

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

Activities of Daily Living (predicted ability on discharge)	Please circle	Support available?	Support Required?	Please specify supports in place or other issues
Bathing/Showering	*Independent/Assisted/Dependent*			
Dressing/Undressing	*Independent/Assisted/Dependent*			
Preparing Meals	*Independent/Assisted/Dependent*			
Grooming	*Independent/Assisted/Dependent*			
Transferring	*Independent/Assisted/Dependent*			
Toileting	*Independent/Assisted/Dependent*			
Footcare	*Independent/Assisted/Dependent*			
Shopping	*Independent/Assisted/Dependent*			
Banking	*Independent/Assisted/Dependent*			
Housework	*Independent/Assisted/Dependent*			
Home Maintenance	*Independent/Assisted/Dependent*			
Transport	*Independent/Assisted/Dependent*			
Medication Manag.	*Independent/Assisted/Dependent*			
Wound Care	*Independent/Assisted/Dependent*			
Other (specify)	*Independent/Assisted/Dependent*			
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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Revised March 2005