Eastern Post Acute Care Program
REFERRAL TOOL
INTERPAC@easternhealth.org.au
EPAC Phone: 9881 1815 EPAC Fax: 9803 2650

UR Number: ___________________________________
Surname: ____________________________________
Given Name: ___________________________________
Date of Birth: ________/________/_______ Sex: M / F

Affix Hospital I.D. Label If Available

☐ **Patient Registration form with Demographics, GP and Next of Kin MUST be attached.**

Discharge address different to Patient ID label? YES / NO – Address and telephone number:

Admission Date: **Hospital:**	**Expected Discharge Date:**	**Referral Date:**	**Ward:** **Treating Unit:**

Referred By: ………………………………………………………………………
(Name and Position): ……………………………………………………………
Referrer Phone: ……………………………………………………………………
Referrer Fax: ………………………………………………………………………

Allergies:

RISKS identified (Infection control, Behaviours)

Advanced Care Directive ☐ Yes ☐ No

POA: Type

Diagnosis/Reason for admission:

Past Medical History:

Services Required and Ongoing Plan:

My Aged Care Referral Completed: YES ☐ **NO** ☐ MAC Referral Number:

Pre Existing Services:

Home Care Package: ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4
NDIS: ☐

Case manager Name:	*Organisation:*	*Phone number:*
Service Type	**Service Provider**	**Frequency**
Nursing		
Personal Care:		
Home Care:		
Delivered Meals:		
Shopping:		
Other:		

Carer Details	***Living Arrangements***	***Accommodation***
☐ Co-Resident Carer	☐ Alone	☐ Independent living
☐ Non-Resident carer	☐ With family	☐ Retirement Village ILU
☐ No Carer	☐ With others	☐ Supported Residential Service

Activities of Daily Living	Independent	Assisted	Supervised	Dependent	**Physical and Mental status at Discharge**
Mobility					Mobility Aids: ☐ SPS ☐ PUF
Transfers					☐ 2WF ☐ 4WF ☐ Crutches Other:
Shopping					Diet:
Personal ADL's					Cognition:

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Client Consent to Referral :

I (Patient name)____

Agree to referral being made to the Eastern Post Acute Care program (EPAC).

Signed: ____

Or Verbally consented: ☐ Yes ☐ No

Documentation Required		Sent to EPAC
All EPAC referrals require a copy of the following :		
Patient Registration		☐
Additional progress notes that will support clinicians to provide care to the patient in their home		☐
All Nursing referrals require a copy of:		
Observation Chart		☐
Medication Chart		☐
Drain tube management	Drain tube chart	☐
Diabetic Management	Medication Chart	☐
	Documented reportable BGL's	☐
	Copies of Diabetic Nurse Educator & Endo team interventions	☐
	Diabetes supplies including: Insulin, Administration device/syringes, Glucometer, Needles, Sharps container	☐
IDC management	Authorisation to change catheter form (details of catheter type, size and insertion date)	☐
	4 weeks supply day and overnight bags, reinsertion kit and catheter	☐
Medication Management	Medication Chart Medication provided/Webster arranged/ Sharps container	☐
Stoma Education /support	Bowel Chart	☐
	Relevant Stoma therapist notes or report	☐
	Stoma supplies provided or ordered by Stomal therapist	☐
Warfarin Administration	Medication Chart Details of pathology company & home pathology visits if organized	☐
Wound Care	Wound Care Chart	☐
	5 changes of dressings must be supplied	☐
Personal Care and In Home Respite	Self Care Summary and OT Assessment	☐
Home Care and Shopping	Any pertinent progress notes that would assist carer eg. OT/SW/PT assessment	☐