FEH090240

easternhealth

AMBULATORY CARE AND COMMUNITY SERVICES REFERRAL FORM

Type or write legibly in black pen

UR Number: ______
Surname: ______
Given Name: ______
Address: ______

Date of Birth: ____/____/____ Sex: ☐ M ☐ F

Affix Hospital ID Label If Available – Internal use

Do NOT use this form to refer to ACAS, Aged Persons Mental Health, Early Supported Discharge, Fast Track Ortho, Transition Care Program, Residential In Reach, GEM@Home or Community Health.

Community Access Unit ph. 9881 1100 Date of Referral: / /

Send this form by fax: 9881 1102 or email: sacs.integratedcare@easternhealth.org.au

Referrer's name: ______ Designation: ______
Location / Organisation: ______ Phone: ______
Client is in hospital or HITH Yes ☐ No ☐ Discharge date: / / N/A ☐
Hospital: ______ Ward: ______ Unit: ______ Program ______

Reason for Referral

Presenting problem or diagnosis and the impact on the client? What does the client need?

Client Information

Interpreter required: Yes ☐ No ☐ If yes, preferred language: ______
GP details: Name: ______ Phone: ______
Client address ☐ or temporary address ☐
Name of carer(s) or NOK: ______ Relationship: ______
Carer(s)/NOK Phones: Ph: ______ Mobile: ______
To make appointment contact: ______ Client ☐ or Carer(s)/NOK ☐

Medical Information

Relevant history, medications or specialists: Home Oxygen ☐ Infection Risk ☐
Does the client have an NDIS Approved plan? Yes ☐ No ☐
Does the client have a Home Care Package? Yes ☐ No ☐ Level ______
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 ☐

Social and Community

Include current community services and relevant social situation.

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 ☐ ______

Home Visit Risk completed Yes ☐ No ☐ EMR Alert Completed Yes ☐ No ☐
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 ☐
Email: ______
Client signature (if appropriate) ______

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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.

	Req.	DC sum.	DC sum CPF
Occupational Therapy	☐	☐	☐
Physiotherapy	☐	☐	☐

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

	Req.	DC sum.	DC sum CPF
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

☐ HARP (Hospital Admission Risk Program)

Client has a chronic health condition and/or psychosocial complexity and requires care coordination to prevent hospital presentation. Client or carer has potential to manage health conditions.

- ☐ Cardiac
- ☐ Diabetes
- ☐ Psychosocial
- ☐ Respiratory
- ☐ Chronic Complex

☐ 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

Specialist Clinics

☐ Continence Clinic

Client requires assessment and management by geriatrician 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 determine 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 Clinic

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.

Intensive Home-based Evaluation and Management

☐ 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

Orientation Session is required in most cases in order to access the service

Total number of pages in referral including attachments:

Referrer Name: ____________________ Signature: ____________________

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