



Ambulatory Care Referral

Surname U.R. No.
First Name Gender
Date of Birth / / Age
Doctor Ward.....

PLACE LABEL HERE

Sex at birth: Gender:

Referrer details:

Name/Designation
Provider no: PH/Fax.....
Hospital/Agency BCH Other
Ward/Unit Date ____/____/____
Email

If Patient is not being discharge to above address, please specify

Address:
Suburb p/code
PH: (HOME)
Mobile
With who?

Referral to: BCH Access Unit via E: access@basscoasthealth.org.au or T: 03 5671 3175 or F: 03 9102 5307

- High risk foot clinic Wound clinic Contenance Specialist falls clinic NP Complex review
- Women's health clinic Urodynamics Stomal ICDM DE
- Falls Prevention Program Respiratory rehab Breast care Cardiac rehab

Allied Health

- PT OT Speech SW Podiatry Dietetics Social Support Group (PAG) Other

Is Home based therapy required Yes No Why

If NO-how will client access clinic? Drive Family/Friend ½ price taxi Public Transport Other

Referral to: BCH Health Independence Programs via T: 03 5671 3135 or HIP@basscoasthealth.org.au

- Post Acute Care** Nursing Personal Care Home Help Shopping assistance Other

Hospital Admission Risk Program/Transition Care Program (select stream & attach info as indicated)
HARP Programs Chronic Heart Failure (echo report) Chronic Respiratory (FRTs for COPD or CT Report)

- Diabetes Co-Management (HBA1c, or other relevant pathology)
- Complex psychosocial needs (psychosocial assessment) **OR** **TCP**

Referral to: District Nursing & Palliative Services via F: 56785183 or district.nursing@basscoasthealth.org.au

If the consumer is being discharged from a public hospital, please also refer via PAC
If the referral is for palliative care, refer directly to district nursing via MR-895

OTHER

Service Name & Type: Contact Details

All referrals **Attached** **Pending** **N/A**

Discharge Summary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Eg / IDC authorisation reportable BGL)

Medicare no & exp:

NDIS/Home care Package Yes No ref no:

Case Manager details:

PAC Personal Care Assistance Mandatory Attachments

Personal Care Plan (PADL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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My Aged Care registered Yes No Ref Date:

MAC ID (if applic):

Please specify whether consumer requires either:

District Nursing (detail clinical reasons eg. shoulder recon, BP, wound)

TAC: Yes No Ref no:

DVA: Yes No Ref no:

Personal Care Attendant

Workcover: Yes No Ref no:

DNS Referrals Mandatory Attachments

Medication Chart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wound chart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hospital Admission date:

Expected Discharge date:

Original medication chart **MUST** be sent home with patient on discharge if referred for medication management

Actual Discharge Date

GP Name:

Allied Health mandatory attachments

AH discharge summary letter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Clinic Details

H/V assessment form (if attended)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 Address

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CLINICAL INFORMATION

Current Diagnosis: _____

 Reasons for referral: _____

 Treatment and response to treatment (eg. Additional referrals, current treatment plan, other agencies involved, falls precautions, routine haemodialysis etc): _____

 Relevant medical, family and social history: _____

SOCIAL, CULTURAL & FUNCTIONAL INFORMATION

Indigenous status: Not ATSI ATSI Aboriginal, not TSI TSI, not aboriginal Not Stated
 Cultural/Linguistic/religious/spiritual background _____ Interpreter required Yes No

Marital Status	Living arrangements/ social	Carer Details	Accommodation	Functional Impacts
<input type="checkbox"/> Married/Defacto <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/separated <input type="checkbox"/> Single <input type="checkbox"/> Not Stated	<input type="checkbox"/> Alone <input type="checkbox"/> With Family <input type="checkbox"/> With others <input type="checkbox"/> Not stated <input type="checkbox"/> Socially Isolated <input type="checkbox"/> Well supported socially	<input type="checkbox"/> No Carer <input type="checkbox"/> Co-resident carer <input type="checkbox"/> Non-resident carer <input type="checkbox"/> Not stated	<input type="checkbox"/> Own home/own rental <input type="checkbox"/> Supported accommodation <input type="checkbox"/> Residential Care <input type="checkbox"/> Short term crisis or transitional housing <input type="checkbox"/> Homeless / none <input type="checkbox"/> Not stated	<input type="checkbox"/> Issues of communication <input type="checkbox"/> Issues of cognition <input type="checkbox"/> Issues of mobility <input type="checkbox"/> Issues of continence <input type="checkbox"/> Other significant issues _____

RISK SCREEN

Clinical: At risk of hospital admission Carer stress At risk of falls Behavioural issues Mental health concerns
 Anaphylaxis/allergies (detail) _____ Adverse drug reactions _____
 List actions taken to minimize risks _____
 Home visit safety Not applicable-referrer unaware of potential safety risks Home visit not required
 Home Visit risks identified (detail) _____

Clinical Urgency Routine High Priority

NEXT OF KIN / ENDURING POWER OF ATTORNEY / MEDICAL TREATMENT DECISION MAKER/PARENT/GUARDIAN DETAILS

NOK Enduring Power of Attorney Medical treatment Decision Maker Parent Guardian
 Is the consumer a dependent Child Yes No
 Name of NOK/EPOA/MTDM/parent/guardian _____
 Contact details of NOK/EPOA/MTDM/parent/guardian
 Address _____
 PH _____ Mobile _____
 Email _____

CONSENT

Verbal consent given for referral to all ticked services Yes No Staff Initials _____
 Verbal consent given for sharing of personal and health information with Health Service Yes No Staff Initials _____

FORM COMPLETED BY:

Name _____ Signed _____
 Designation _____ Date _____

AMBULATORY CARE REFERRAL

MR/313