Ambulatory Care Referral

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

PLACE LABEL HERE

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 ☐ Continence ☐ 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 & DNS 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**

☐ **District Nursing Services/Palliative** (NOTE: if referral is for an existing condition, refer directly to DNS via MR306)
*NOTE: if referral is for a new condition or an alteration to a pre-existing condition, and the consumer is being discharged from hospital, refer via PAC

OTHER

Service Name & Type: ________________________ Contact Details ________________________

All referrrals	**Attached**	**Pending**	**N/A**
Discharge Summary	☐	☐	☐
Other	☐	☐	☐
(Eg / IDC authorisation reportable BGL)			
PAC Personal Care Assistance Mandatory Attachments			
Personal Care Plan (PADL)	☐	☐	☐

Please specify whether consumer requires either:
☐ District Nursing (detail clinical reasons eg. shoulder recon, BP, wound) ________________________
☐ Personal Care Attendant

DNS Referrals Mandatory Attachments			
Medication Chart	☐	☐	☐
Wound chart	☐	☐	☐

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

Allied Health mandatory attachments			
AH discharge summary letter	☐	☐	☐
H/V assessment form (if attended)	☐	☐	☐

Medicare no & exp: ________________________
NDIS/Home care Package ☐ Yes ☐ No ref no: ____________
Case Manager details: ________________________
My Aged Care registered ☐ Yes ☐ No Ref Date: ____________
MAC ID (if applic): ________________________
TAC: ☐ Yes ☐ No Ref no: ____________
DVA: ☐ Yes ☐ No Ref no: ____________
Workcover: ☐ Yes ☐ No Ref no: ____________

Hospital Admission date: ________________________
Expected Discharge date: ________________________
Actual Discharge Date ________________________
GP Name: ________________________
Clinic Details ________________________

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AMBULATORY CARE REFERRAL

MR/313

Ambulatory Care Referral

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

PATIENT LABEL

PLACE LABEL HERE

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
☐ Married/Defacto	☐ Alone	☐ No Carer	☐ Own home/own rental	☐ Issues of communication
☐ Widowed	☐ With Family	☐ Co-resident carer	☐ Supported accommodation	☐ Issues of cognition
☐ Divorced/separated	☐ With others	☐ Non-resident carer	☐ Residential Care	☐ Issues of mobility
☐ Single	☐ Not stated	☐ Not stated	☐ Short term crisis or transitional housing	☐ Issues of continence
☐ Not Stated	☐ Socially Isolated		☐ Homeless / none	☐ Other significant issues
	☐ Well supported socially		☐ Not stated	____________________

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