BCH Bass Coast Health

Ambulatory Care Referral

Surname ..... U.R. No. .....

First Name ..... Gender .....

PATIENT LABEL

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 ☐ 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 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	☐	☐	☐
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 _____

_____

AMBULATORY CARE REFERRAL

MR/313

BCH3313

BCH, V4 Aug 2024

BCH Bass Coast Health

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First Name ..... Gender .....

PATIENT LABEL

Date of Birth ... / ... / ... Age .....

Doctor ..... Ward .....

Address .....

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