Ambulatory Care Referral

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

PATIENT LABEL

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 ❑ Falls & Balance ❑ GEM (NP)
- ❑ Women's health clinic ❑ Urodynamics ❑ Stomal ❑ ICDM ❑ DE
- ❑ Rehabilitation ❑ Respiratory ❑ Breast care ❑ Cardiac

❑ **Allied Health/CNC/NP**

❑ Clinical Nurse Consultant/Nurse Practitioner Service (specify type)______________________

❑ 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 MR426)
*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

TRIAL24092019

BCH33 13

MR/313

BCH, V2 Aug 2019

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 heath 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

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