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

Referrer details:

Name/Designation _____

Provider no: _____ Phone:_____

Agency: ☐ BCH ☐ Other _____

Ward/Unit: _____ Date ___/___/_____

Email: _____

Patient Details: *(if additional to above)*

Sex at Birth: _____

Discharge Address: _____

Suburb: _____ P/code: _____

Phone (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 ☐ Cardiac Rehab ☐ Diabetic Educator
☐ Falls Prevention ☐ Respiratory ☐ Breast care ☐ Integrated Chronic Disease Management

☐ **Allied Health:** ☐ Physiotherapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Dietetics
☐ Podiatry ☐ Social Work ☐ Social Support Group ☐ Counselling ☐ 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 E: HIP@basscoasthealth.org.au or T: 03 5671 3135*

☐ **Post Acute Care (PAC):** ☐ Nursing ☐ Personal Care ☐ Home Help ☐ Shopping assistance
☐ Other: _____

☐ **Hospital Admission Risk Program / Transition Care Program (TCP)** *(select stream & attach info as indicated)*

☐ Chronic Heart Failure *(echo report)* ☐ Chronic Respiratory *(FRTs for COPD or CT Report)*
☐ Diabetes Co-Management *(HBA1c or relevant pathology)*
☐ Complex psychosocial needs *(psychosocial assessment)* ***or*** ☐ **TCP**

Referral to: District Nursing & Palliative Services *via E: district.nursing@basscoasthealth.org.au or F: 03 5678 5183*

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/316

Referral to Other Service:

Service Name & Type: _____ Contact Details _____

All referrals	Attached	Pending	N/A
Discharge Summary	☐	☐	☐
Other *(specify below):*	☐	☐	☐

_____

PAC Personal Care Assistance Mandatory Attachments

Personal Care Plan (PADL)	☐	☐	☐

Please specify whether consumer requires either:

☐ District Nursing *(detail clinical reasons):* _____

_____

☐ Personal Care Attendant

District Nursing Service 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	☐	☐	☐
Home Visit Assessment Form *(if attended)*	☐	☐	☐

Provider Information

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: _____

Admission Details

Hospital Admission date: _____

Expected Discharge date: _____

Actual Discharge Date _____

GP Name: _____

Clinic Details _____

_____

AMBULATORY CARE REFERRAL

MR/313

BCH313

BCH, V5 Apr 2025

AMBULATORY CARE REFERRAL

MR/313

BCH Bass Coast Health

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PATIENT LABEL

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

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

Address .....

PLACE LABEL HERE

Clinical Information

Current Diagnosis: _____

_____

Reasons for referral: _____

_____

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

_____

Relevant medical, family and social history: _____

_____

Social, Cultural and Functional Information

Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ BOTH Aboriginal & TSI

☐ NOT Aboriginal or TSI ☐ Not Specified ☐ Refused to answer ☐ Question unable to be asked

Cultural/Linguistic/religious/spiritual background: _____ Interpreter required? ☐ Yes ☐ No

Marital Status	Living Arrangements and Social	Carer Details	Accommodation	Functional Impacts
☐ Married/Defacto	☐ Alone	☐ No Carer	☐ Own home / rental	☐ Issues of communication
☐ Widowed	☐ With Family	☐ Co-resident carer	☐ Supported accom.	☐ 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:
	☐ Socially Supported		☐ 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

Additional Contact Details *(Next of Kin, Enduring Power of Attorney, Medical treatment Decision Maker, Parent/Guardian)*

☐ Next of Kin ☐ 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 _____