Affix Hospital Label Here Please note yellow fields are mandatory.	(for ACT staff use only) Date of initial contact: _____ Signature _____ Date of final contact: _____ Signature _____	Health Sydney Local Health District

SLHD Aged Chronic Care and Rehabilitation REFERRAL FORM

1. CLIENT DETAILS:

MRN (if known): _____

Date of Referral to Service: _____ Ready for Care Date (if different): _____

Title: _____ Last Name: _____ First Name: _____

Sex: ❑Male ❑Female ❑Other Birth Date: _____ Estimated DOB: Yes ❑ No ❑

Medicare: ❑Eligible Australian Resident ❑Ineligible Overseas Resident ❑Reciprocal Overseas Resident ❑Unknown
Medicare Number_____

Home Address: _____ Suburb: _____ Postcode: _____

Telephone: (home) _____ (work) _____ (mobile): _____

Marital Status: ❑Married ❑Never Married ❑Defacto ❑Widowed ❑Divorced ❑Separated ❑Unknown

Current Temporary Address/or Hospital : _____ Tel: _____

Country of Birth:_____ Preferred Language :_____

Interpreter required: ❑No ❑Yes ❑ Unknown
Indigenous Status: ❑Aboriginal ❑Torres Strait Islander ❑ Both Aboriginal and Torres Straight Islander ❑ Neither ❑ Unknown
Government Benefit: ❑Aged ❑Disability ❑ DVA ❑Carer Pension ❑Other Gov Pension ❑ None ❑ Unknown
DVA Entitlements: ❑ Gold ❑ White ❑ Orange ❑ No Card ❑ No entitlement ❑ Not Known /Not Stated

GP Name: _____ Tel: _____

Address: _____ ❑ No GP ❑ GP not known

GP email : _____ Fax:_____

2. REFERRER DETAILS:

Referrer Name: _____
Organisation: _____ Tel: _____ Fax: _____
Referrer's email address: _____
Relationship to client: _____

3. LIVING ARRANGEMENTS:

Usual Accommodation Setting:
❑ Privately Owned Home ❑ Private Rental ❑ Dept. Housing ❑ RACF-low ❑ RACF-high
❑ Independent Living / Retirement Village ❑ Boarding House ❑ Public place (homeless) ❑ Mobile home
❑ Other: _____
Living Situation: (NB – tick more than 1 box if appropriate) ❑Lives Alone ❑ With Spouse/Partner ❑ With Children
❑ With Other Relatives ❑ With Others_____ ❑ Not known /Not Stated

4.CARER DETAILS:

CARER DOB (if known):_____ ❑ Tick If Details Same as Person to Contact
Relationship to Client: _____
Title:_____ Last Name:_____ First Name: _____
Address: _____ Suburb: _____ Postcode: _____ State: _____
Tel : (H) _____ (W) _____ (Mob)_____
Carer Status: ❑Co-resident ❑Non-resident ❑ No carer ❑Not known / Not Stated
Does the Carer need an Interpreter? ❑ Unknown ❑No ❑Yes, _____
Does the Client have an Appointed Financial Manager / Guardian? ❑No ❑ Unknown ❑Yes If Yes, Details Below
_____

5. PERSON TO CONTACT FOR ASSESSMENT

❑ Tick If Details Same as Carer Details
Relationship to Client: _____
Title: _____ Last Name: _____ First Name: _____
Address: _____ Suburb: _____ Postcode: _____ State:_____
Tel : (H) _____ (W) _____ (Mob)_____

Client Name:_____ **MRN (If Known):**_____

SLHD Aged Chronic Care & Rehabilitation REFFERAL FORM – Page 2

6. REFERRAL INFORMATION:

Does the client consent to this referral? ❑ Yes ❑ No ❑Unknown

Is the GP Aware of this Referral? ❑Yes ❑ No ❑Unknown

7. CURRENT COMMUNITY SUPPORTS (if yes, whom and how often):

- ❑ Community Nursing:_____ ❑ Case Management: _____
- ❑ Community Transport:_____ ❑ Home Care Package:_____
- ❑ Centre-based Day Care:_____ ❑ Home Care:_____
- ❑ Meals on Wheels:_____ ❑ Private Cleaning:_____
- ❑ Other professionals involved:_____

8. IDENTIFIED ISSUES/ REASON FOR REFERRAL:

Which service is referral for? (if known):

Medical History / Medical Issues (eg significant illness/allergies/delirium risk/recent onset of confusion/change in behaviour/risk of wandering or absconding):

Mental Health History / Issues (eg risk of suicide, psychological interventions, providers/services involved including Drug Alcohol

Social History (eg information on family and personal history, networks, parental or other caring responsibilities, concerns regarding living situation/any risk of violence):

Functional/Mobility Status (eg Activities of Daily Living, current/change in functioning and supports):

Risk of Falls (history of falls in the last 12 months, four or more medications, problems with balance, inability to rise from chair without using arms):

Any other information?

SUBMIT RESET