

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 De facto 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 Strait 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): _____

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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):

- | | |
|--|---|
| <input type="checkbox"/> Community Nursing: _____ | <input type="checkbox"/> Case Management: _____ |
| <input type="checkbox"/> Community Transport: _____ | <input type="checkbox"/> Home Care Package: _____ |
| <input type="checkbox"/> Centre-based Day Care: _____ | <input type="checkbox"/> Home Care: _____ |
| <input type="checkbox"/> Meals on Wheels: _____ | <input type="checkbox"/> Private Cleaning: _____ |
| <input type="checkbox"/> 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 History /Use):

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?

