



CHAIN REFERRAL AND CLINICAL HANDOVER FORM

The client lives in the boundaries of Sydney Local Health District South Western Sydney Local Health District

Date of referral to CHAIN: Date ready for care: MRN:

REFERRER DETAILS

Name (PRINT) Telephone Fax Pager no.

Referring Service

Client Aware of Referral to Service Yes No Unknown

CLIENT DETAILS

Title Family Name First Name Middle Name

Sex Date of Birth Estimated Date of Birth Yes No

Medicare No: Expiry Date:

Health Insurance Fund/DVA: Membership No:

Workcover Provider: Claim No:

Treatment Address Lives alone Lives with others, specify:

Street Suburb Postcode

Telephone:(Home) (Work) (Mobile)

Residential Address As above

Street Suburb Postcode

Telephone (Home) (Work) (Mobile)

Country of Birth Preferred Language

Interpreter Required Yes No Unknown

DOCTOR RESPONSIBLE FOR CARE & REVIEW

AMBULATORY DOCTOR MEDICAL SPECIALIST GENERAL PRACTITIONER

Name Pager/ mobile phone Next review date

GP DETAILS

GP Name Telephone Fax

CHECKLIST (Y/N)

MEDICATIONS SENT HOME WITH CLIENT

ORIGINAL COMMUNITY HEALTH MEDICATION CHART SENT HOME WITH CLIENT

COMMUNITY HEALTH AUTHORITY TO PERFORM CLINICAL PROCEDURES SENT WITH CLIENT

ELECTRONIC DISCHARGE SUMMARY COMPLETED IN CERNER

WOUND CARE EQUIPMENT/ SUPPLIES SENT HOME WITH CLIENT

NEXT OF KIN/ PERSON TO CONTACT DETAILS

Name (PRINT) Relationship to Client

Telephone (Home) (Work) (Mobile)

Address

BINDING MARGIN - NO WRITING

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AMR018.003



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Client Family Name: _____ First Name: _____ Date of Birth: _____ MRN: _____

Diagnosis /History

Reason for referral /treatment requested/wound treatment

Allergies _____

Current Services _____

Is this a recurrent condition? Yes [] No []

Is a further medical consult required? (eg. infectious diseases consult for complicated cellulitis) Yes [] No []

Details _____

OCCUPATIONAL HEALTH & SAFETY (Tick the relevant column)	YES	NO	UNKNOWN
Known Infectious Disease			
Known Multiresistant Organism			
Cytotoxic Medication (eg. for Cancer, Arthritis, Psoriasis)			

Comments: _____

RISK ASSESSMENT— MUST BE COMPLETED FOR ALL REFERRALS (Tick the relevant column)	YES	NO	UNKNOWN
Current problems with alcohol and substance misuse			
Domestic Violence			
Animals of concern at home (if yes, request they be locked up prior to home visit)			
Safety issues. Precautions or protocols to be taken during administration of requested medications (if yes, ask for information to be faxed and original given to client.			
Behavioural issues (eg. aggression)			
Environmental risks for staff (eg. building works, weapons, poor access/lighting)			

Comments: _____

COMMUNITY HEALTH ACCESS INTAKE NURSING (CHAIN)

Fax number: 9767 7026 Telephone: 1300 722 276 email: Concord.CHAIN@sswahs.nsw.gov.au

Faxed and email submitted referrals are not considered accepted until phone confirmation is obtained by CHAIN

BINDING MARGIN - NO WRITING