This form should be completed online then Printed

RESET

Health
Sydney
Local Health District

COMMUNITY HEALTH NURSING

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

CHAIN REFERRALAND CLINICAL HANDOVER FORM

AMR018.003

July 12/Rev 4

Health
Sydney
Local Health District

NSW GOVERNMENT

COMMUNITY HEALTH NURSING

CHAIN REFERRAL AND CLINICAL HANDOVER FORM

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

SUBMIT RESET

BINDING MARGIN - NO WRITING