WHCOR29

Western Health

Western Continence Service

Referral Form

Fax referral to 8345 4054

Email: Continence@wh.org.au

Hospital UR#.....

Name: .....

Address: .....

Suburb: .....

Postcode: ..... **Telephone:** .....

DOB:_____/_____/_____**Marital Status:** .....

Referrers Name: ..... Position: .....Tel / Page .....

Referring Hospital / Agency / Clinic: ..... Unit: .....Ward:.....

Referred from: ☐ Acute Hospital ☐ Sub Acute / Rehab / GEM ☐ Community Agency ☐ Self / carer

☐ Emergency ☐ Hospice / Palliative Care ☐ Medical Specialist ☐ General Practitioner

If client is NOT being discharged to, or currently residing at their usual address, please specify alternative address: .....

..... Tel: ... .

Hospital Admission Date: / / Hospital Discharge Date: / / ☐ not applicable

Contact Person/Net of Kin: ..... Tel: .....

Address: ..... Work: .....

Relationship: ..... Mobile: .....

Primary Carer: Yes ☐ No ☐

Case Manager: (if Relevant): ..... Tel: .....

Agency: ..... Mobile: .....

Reason for Referral: (External referrals please attach any additional information e.g. discharge summaries, investigations)

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Incontinence: ☐ Urinary ☐ Faecal

☐ Recurrent UTI's ☐ Other: .....

Frequency of Problem:.....

Duration of Problem: .....

Other: .....

Previous Continence Assessment: ☐ Yes ☐ No ☐ By Whom ..... Year .....

Requires:

☐ ISC Instruction ☐ Urodynamic Studies ☐ Pelvic Floor Physiotherapy ☐ General Continence Assessment

Relevant Medical/Surgical History: .....

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Current Medications (attach medication list if available): .....

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WHCOR29

Cognitive State:

☐ Normal ☐ Minor changes ☐ Confusion ☐ Dementia

Mobility:

☐ Independent ☐ Assisted ☐ Unable

Care Package:

☐ CACPS Linkages ☐ EACH ☐ EACH Dementia ☐ Other

Case Manager: ..... Telephone: .....

Organisation: .....

Address: .....

New Referrals to other Agencies:

☐ RDNS ☐ ACAS ☐ Other

Has the patient consented to this Referral: ☐ Yes ☐ No

Contact Person for Appointments: ..... Tel: .....

Address: ..... Work: .....

Relationship: ..... Mobile: .....

Any factors impacting on ability to attend a clinic appointment: .....

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COMPLETE BELOW FOR REFERRALS FROM OUTSIDE WESTERN HEALTH

GP Name: ..... Tel: .....

Clinic Name: ..... Fax: .....

Address: ..... Mobile: .....

Is GP aware of Referral ☐ Yes ☐ No

Interpreter Required: ☐ Yes ☐ No Language: .....

Carer Availability	**Carer Relationship**	**Living Arrangements**	**Accommodation**
☐ No Carer	☐ Spouse/Partner	☐ Lives Alone	☐ Private (own/rent/purchase)
☐ Co-resident Carer	☐ Parent	☐ Lives with Family	☐ Outreach
☐ Non Resident Carer	☐ Child	☐ Lives with Others	☐ Supported Community
	☐ Child-in-law	☐ Not stated	☐ Residential Aged Care
	☐ Other Relative		☐ Residential Care Facility (not aged)
	☐ Friend/Neighbour		☐ Short Term Crisis/Emergency
	☐ Foster Carer		☐ Other Accommodation

Country of Birth:

Aboriginal or Torres Strait Islander ☐ Yes ☐ No

Medicare No:

Pension No:

DVA No: (if applicable)

TAC ☐ Yes ☐ No Claim Number:

Workcover ☐ Yes ☐ No Claim Number: