WHAD172

Western Health

COMMUNITY ACCESS REFERRAL FORM for PAC, CBR, and HARP

Referral Date ______/______/______

Fax referral to 8345 6529 for the following service:

☐ **Post Acute Care (PAC)**

☐ **Sunshine Community Based Rehab (CBR)**

☐ **Williamstown Community Based Rehab (CBR)**

attach Bradma or complete details

Hospital UR # …………………………………………………………………

Name: …………………………………………………………………

Address: …………………………………………………………………

Suburb: …………………………………………………………………

Postcode: ………………. **Tel**: …………………………………………

DOB: _____/_____/_____ **M / F** **Marital status**

☐ **HARP (circle program)** Complex Needs / Psychosocial / Diabetes / Cardiac/ Respiratory / Paediatric Asthma

☐ **HARP Clinics:** Chronic Heart Failure / Diabetes Western Region Health Centre (WRHC)/ Diabetes ISIS Primary Care

☐ **Exercise Rehab program (circle program)**: Chronic Heart Failure / Cardiac / Pulmonary

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 ☐ 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:………………………………………………………………………………………… Tel: ……………………………………

Address: ………………………………………………………………………………………………… Work: …………………………………

Relationship ………………………………………………………… Primary carer Yes / No Mobile: ……………………………….

Guardian (if relevant) :……………………………………………………………………………………. Tel: …………………………………

Case Manager: (if relevant)……………………………………………………………………………. Tel: …………………………………

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

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

Practice Name:…………………………………………………………………………………………. Fax: ……………………………………….

Address:……….

Cultural Information: Aboriginal / Torres Strait Islander Yes / No

Country of Birth: ………………………………………………. Languages Spoken: ……………………………………………………………

Is interpreter required for: Simple information? Yes / No ……….Complex / medical information? Yes / No

Religious affiliation: ………………………………………………………… Specific cultural requirements: ……………………………………………

Main diagnosis / Reason for admission to hospital :

……

……

Other health issues/past medical history……………………………………………………………………………………………………

……

……

Any infectious diseases:……..

Any allergies? …….

Current medications ……..

……

……

(or attach list if available in another format, eg: discharge summary, Medical Director report, etc – *not required for post acute care home care referrals*)

Goals of Treatment / Expected Outcome of Care…………………………………………………………………………………………

……

……

……

……

……………………………………………………………………………………… Is the patient at risk of re-presenting to hospital? ☐ Yes ☐ No

AD 172

REFERRAL FOR POST ACUTE CARE, CBR and HARP

Social Issues: **Patient Name**:. ………………………………………………UR:……………..

……

……

……

Does the client provide care for others? Specify……………………………………………………………………

……

Accommodation type	**Ownership**	**Lives with**	**Funding & Pension Status**
☐ House	☐ Owner	☐ Lives Alone	☐ Pension Type:…………………………..
☐ Flat / Unit	☐ Private Rental	☐ With Spouse / Partner	☐ Workcover pending ☐ approved
☐ Boarding House	☐ Ministry of Housing	☐ With other relatives/ children	Claim # ……………………………….
☐ Hostel / SRS	☐ Other.	☐ With other person.	☐ TAC pending ☐ approved
☐ Homeless	Specify:……………………	Specify: ……………………..	Claim # ……………………
☐ Other. …………………..	…………………………….	………….………………………	☐ DVA entitlement Card type: White / Gold
………………………………	……………………………	………………………………….	Number …………………………………

Safety / Access Issues - some patients may require either a home visit or treatment in the home. Please specify any issues about the discharge environment that may affect the care or safety of:

☐ Client / Carer. ……………………………………………………………………………………………………

☐ Service Provider ……………………………………………………………………………………………………

(eg: dogs, firearms, steep or slippery stairs, substance abuse, verbal or physical violence or family conflict)

Can the patient travel in a car? ☐ Yes ☐ No Does the patient require the front seat ? ☐ Yes ☐ No

Is there a reason that rehab must be provided at home? ☐ Yes ☐ No Reason ……………………………………………………

……

Please complete for Post Acute Care, HARP, Community Based Rehab clients (not required for Community TCP):

Client Agreement:

I ………………………………………………………………… (client name) agree:-

- to participate in the Post Acute Care, HARP, and/or Community Based Rehab program and
- that **information about my medical condition and care needs** can be supplied to the staff of these programs and the services providing assistance to me, including my local doctor,
- that the staff may feed back to the hospital staff about my recovery and the care needed

SIGNED: ……………………………………………………………………………(client) DATE: ………………..

NON ENGLISH SPEAKING

If English is not my first language I acknowledge that the service has been explained to me with the assistance of an interpreter.

SIGNED: ……………………………………………………………………………… (client) DATE: ………………

CARER / GUARDIAN CONSENT

If the client is unable to give informed consent the guardian or a carer may sign on his/her behalf.

SIGNED: ……………………………………… (carer) DATE: …………… RELATIONSHIP: ………………………………

Nursing and Allied Health Assessments: Hospital staff please fax copies of discharge summaries where relevant. Follow up needed?

Physiotherapy	Name ………………………………………	Tel / Page: ………………………………	Yes / No
Social Work	Name ………………………………………	Tel / Page: ………………………………	Yes / No
Dietician	Name ………………………………………	Tel / Page: ………………………………	Yes / No
Speech Pathology	Name ………………………………………	Tel / Page………………………………	Yes / No
Key Nurse contact	Name ………………………………………	Tel / Page………………………………	Yes / No
Occupational Therapy	Name ………………………………………	Tel / Page………………………………	Yes / No
Other	Name ………………………………………	Tel / Page: ………………………………	Yes / No

☐ OT Home assessment completed Date of visit _____/_____/_______

☐ OT Home assessment pending Date planned _____/_____/_______ ☐ OT Home assessment not required

AD 172

Patient Name & UR:. ……………………………………………………

WHAD172

AD 172

Current Functional status

	Independent	Assisted	Cannot Do	Uses Aids (What?)	Comments and precautions
Mobility					Weight bearing status?
Transfers					
Stairs					
Bathing/Showering					
Dressing					
Toileting – bladder bowels					
Medication					
Shopping					
Meal Preparation					
Eating					
Housework					
Banking/bills					
Transport					

	Normal / No Issue	Impaired / Issues	Comments and precautions
Cognition			
Behaviour			
Mood			
Comprehension			
Communication			
Nutrition			special diet? weight change?
Swallowing			
Vision			glasses?
Hearing			hearing aids?
Skin integrity / wound care			If wound care required, please attach comprehensive information and wound care regime
Pain			Location? Management?
Falls in last 6/12s			Where?

This section is for Services required under Post Acute Care or HARP.

(Please detail **SPECIFIC** service, task or need and suggested frequency) (Examples of some of the available services include: wound care, medication management, home care, health education, personal care, assistance with shopping banking, meal preparation, etc – services are available short term to assist with recovery after a public hospital presentation)

………

………

………

………

………

………

………

Other Services - currently in place or newly referred to on discharge.

Service (ie MOW, Home help, Physio, Taxi card))	**Agency** (ie Council, TAC, DVA, Private Co etc)	Frequency	Existing service in place (tick)	New referral made on discharge (tick)