WHAD172

Western Health

COMMUNITY ACCESS REFERRAL FORM for PAC, CBR, and HARP

attach Bradma or complete details

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)**

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:………

<u>Cultural Information:</u> 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 :

……

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

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Any infectious diseases:……

Any allergies? ……

Current medications ………

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(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……………………………………………………………………………………………

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

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REFERRAL FOR POST ACUTE CARE, CBR and HARP

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

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

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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 ……………………………………………………

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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

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

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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)

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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)