Western Health

COMMUNITY ACCESS REFERRAL FORM
for PAC, CBR, HARP and PACES

WHAD172

Referral Date _____/_____/_____

Fax referral to 8345 1134 for the following service:

☐ **Post Acute Care (PAC)**

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

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

☐ **PACES (Parkinson's Advice, Community Education & Support**

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

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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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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)

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