

Community Nursing & Allied Health Referral

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<p>DATE OF FIRST VISIT: ____ / ____ / ____</p> <p>CLIENT DETAILS: UR/DVA No.: _____ Surname: _____ Title: _____ Given Names: _____ D.O.B: ____ / ____ / ____ Address: _____ Suburb: _____ PC: _____ Phone: _____ Mobile: _____ Language spoken: <input type="checkbox"/> English <input type="checkbox"/> Other: _____ Interpreter Required? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the client aware of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>EMERGENCY CONTACT: _____ Relationship: _____ Phone: _____ Mobile: _____ Work: _____</p> <p>CLIENT'S PRESENTING DIAGNOSIS/PROBLEM: _____ _____ _____ _____</p> <p>PAST MEDICAL HISTORY: _____ _____ _____ _____</p> <p>SPECIAL INSTRUCTIONS? _____ _____</p>	<p>VISIT FREQUENCY REQUIRED: _____</p> <p>MENTAL STATE <input type="checkbox"/> Orientated / Alert <input type="checkbox"/> Short Term Memory Loss <input type="checkbox"/> Confused</p> <p>MOBILITY <input type="checkbox"/> Independent <input type="checkbox"/> Assistance Required <input type="checkbox"/> Full Assistance <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bed bound</p> <p>HEARING <input type="checkbox"/> No problem <input type="checkbox"/> Partially Deaf <input type="checkbox"/> Deaf</p> <p>VISION Impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, condition: _____</p> <p>MEDICATION <input type="checkbox"/> Self <input type="checkbox"/> Carer <input type="checkbox"/> RN</p> <p>CARER STATUS <input type="checkbox"/> Resident Carer <input type="checkbox"/> Non-Resident Carer <input type="checkbox"/> Lives alone</p> <p>RISK ASSESSMENT: Pets? <input type="checkbox"/> No <input type="checkbox"/> Yes Have there been any incidents with the client/family members or visitors that may raise safety concerns for Health Care Workers? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes in any of the above, please comment: _____ _____</p> <p>OTHER SERVICES INVOLVED: <input type="checkbox"/> Veterans' Homecare <input type="checkbox"/> Meals on Wheels <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Other _____ <input type="checkbox"/> ACAT Assessment: Date: ____ / ____ / ____ <input type="checkbox"/> High <input type="checkbox"/> Low</p> <p>FUNDING SOURCE: DVA <input type="checkbox"/> Gold Card Holder <input type="checkbox"/> White Card Holder <input type="checkbox"/> Private <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Third Party Insurance <input type="checkbox"/> Other _____</p> <p>Claim No.: _____ Case Manager: _____ Name of Insurance Co: _____ Phone: _____ Mobile: _____ Fax: _____ Email: _____</p>
<p>ALLERGIES/ADVERSE REACTIONS? _____ _____ <input type="checkbox"/> Nil Known Allergies</p> <p>KNOWN INFECTIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____</p>	<p>1. REFERRER'S DETAILS: Name: _____ Institution: _____ Position: _____ Ward: _____ Address: _____ Phone: _____ Pager: _____ Fax: _____ Provider No.: _____ X _____ / / Referrers Signature (Essential for DVA)</p>
<p>SERVICE REQUIRED: <input type="checkbox"/> Nursing Assessment <input type="checkbox"/> IV Therapies <input type="checkbox"/> Continence Management <input type="checkbox"/> Post Acute Care <input type="checkbox"/> Diabetes Management <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Hygiene/Personal Care <input type="checkbox"/> OT Assessment <input type="checkbox"/> DVA HomeFront Falls Assessment <input type="checkbox"/> Palliative Care <input type="checkbox"/> Medication Management (please provide written authority) <input type="checkbox"/> Supervision of Medication - Webster/Blister Pack <input type="checkbox"/> Wound Management: Type: _____ Comments: _____ _____ _____ _____</p>	<p>2. GP'S DETAILS: (if GP is referrer fill-in part 1 only) Name: _____ Address: _____ Suburb: _____ Prov No.: _____ Phone: _____ Fax: _____</p>

PLEASE ENSURE 3 DAYS OF DRESSINGS ARE PROVIDED