st vincent's home

Community and Ambulatory Services Referral

MRN		SURNAME	
OTHER NAMES			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

Intake of referrals Monday-Friday only.
All referrals received after 2pm will be processed the following business day. Incomplete referrals will not be accepted.
If you would like assistance, please call the O'Brien Referral Centre staff on 8382 1450.
Email completed referral forms to ***svhs.orc@svha.org.au***

Referrer Details

Date of Referral:_____/_____/_____ Referred by:_____

Phone:_____ Mob:_____ Email:_____

Organisation:_____ Designation:_____

Address/Ward and Hospital:_____

Client Details

Address: (*If different to Patient Information Label*)_____

Suburb:_____ Postcode:_____ Email:_____

Phone: Home_____ Mobile_____ Work_____

Preferred method of contact:_____ Language:_____ Interpreter required: ☐ Yes ☐ No

Communication issues: *(e.g. sensory impairment, literacy difficulties)*_____

☐ Aboriginal ☐ Torres Strait Islander Is client aware of referral: ☐ Yes ☐ No

My Aged Care ID (clients ≥ 65 yrs): ☐ Yes ☐ No Number:_____

Does the client have a Home Care Package? ☐ Yes (Level of HCP:____) ☐ No ☐ Unknown

Nominated person for contact:_____ Relationship to client:_____

Address:_____ Suburb:_____

Phone: Home:_____ Mobile:_____ Work:_____

GP:_____ **Phone:**_____ **Suburb:**_____

Financial Details

DVA Gold Card: ☐ Yes ☐ No Number:_____

Medicare No.:_____ Expiry:____/_____

Pension: ☐ Yes ☐ No Number:_____

Reason for Referral

SERVICES REQUIRED (Please tick ☑)

☐ Community Nursing	☐ Physiotherapy	☐ Occupational Therapy	☐ Social Work
☐ Diabetes Centre	☐ Heart Failure – Nurse Led	☐ COPD Outreach	☐ High Risk Foot Service
☐ Dementia Advisory Service	☐ Specialist Wound Clinic	☐ Chronic Care Coordination	
☐ Community Podiatry Service		☐ Infusion Centre / General Ambulatory Care	

For Hospital in The Home Referrals, please see HITH Referral Form

WorkCover treatment: ☐ Yes ☐ No **Medicare treatment:** ☐ Yes ☐ No **URGENT:** *(less than 48 hours)* ☐ Yes ☐ No

COMMUNITY AND AMBULATORY SERVICES REFERRAL

OPD

st vincent's home

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MRN		SURNAME	
OTHER NAMES			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

Medical History

What is the patient's Resuscitation Status? *(Please attach to Referral)*_____

Are there Advance Care Directives in place? *(If yes, please attach to Referral)* ☐ Yes ☐ No

Known Allergies

Work Health Safety Risk Screen

Has the patient received antineoplastic (cytotoxic) medication within the last 7 days? ☐ Yes ☐ No

Are there barriers to visiting / safety issues: *(e.g. access to home, parking, pets, smoking, weapons)*	☐ Yes ☐ No *If Yes, please list:*

Violence Risk Screen

Past History of Risk:	☐ Yes ☐ No ☐ Unknown *If Yes, provide details*:_____			
Recent behaviour suggesting risk:	☐ Yes ☐ No ☐ Unknown *If Yes, provide details*:_____			
Personal Risk Assessment:	Verbally threatening: ☐ Yes ☐ No		Physical acts of aggression: ☐ Yes ☐ No	
	Sexual harassment: ☐ Yes ☐ No		Behavioural disturbances: ☐ Yes ☐ No	
	Other possible risks: ☐ Yes ☐ No			
	*If 'yes' to presence of risk/s, provide further details:*_____			

Additional Client Details

Communication impairment	**Cognition**	**Mobility**	**Continent**
Speech ☐ Yes ☐ No	Oriented ☐ Yes ☐ No	☐ Independent	Urine ☐ Yes ☐ No
Hearing ☐ Yes ☐ No	Confusion ☐ Yes ☐ No	☐ Independent with aid	Faeces ☐ Yes ☐ No
Vision ☐ Yes ☐ No	☐ New ☐ Old	☐ Assist x 1 / x 2	Self caring ☐ Yes ☐ No
Aids:	☐ Deterioration	☐ Wheelchair	Has the patient been referred to a continence specialist before?
	Dementia diagnosis ☐ Yes ☐ No	☐ Bed bound	☐ Yes ☐ No ☐ N/A
		☐ History of falls	

Social	**Accommodation**	**Palliative Care**	**Supporting documents attached with referral**
Lives alone ☐ Yes ☐ No	☐ Home owner	Known to Palliative Care	☐ Hospital Discharge Summary
Carer ☐ Yes ☐ No	☐ Rental ☐ Private ☐ Public	☐ Yes ☐ No	☐ GP Management Plan
Carer burden ☐ Yes ☐ No	☐ Boarding house	Endstage ☐ Yes ☐ No	☐ My Aged Care referral *(must be completed for clients ≥ 65 years)*
Carer lives w/client ☐ Yes ☐ No	☐ Unknown		☐ Team Care Arrangement
	☐ Other:		

WRITING