Health

Facility:

ComPacks REFERRAL

SMR010057

FAMILY NAME		MRN
GIVEN NAME		☐ MALE ☐ FEMALE
D.O.B. ______ / ______ / ______	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Discharge Add: | Medicare No:

Phone: | Mobile:

This Referral Came From: ☐ Hospital in the Home/APAC ☐ Healthy at Home ☐ Ward

Estimated Date of Discharge: ____ / ____ / ______ | Does the Client Consent to this Referral? ☐ Yes

Client Emergency/Alternate Contact Name:

Phone: Relationship to Client:

GP Name:

Phone: Suburb:

☐ DVA Gold Card Holder ☐ Workers Comp Claim ☐ MVA Insurance Claim

☐ Other:

Upon discharge home will the client able to manage independently for the next 48 hours: ☐ Yes ☐ No

Are you of Aboriginal or Torres Strait Islander Origin?

☐ Yes – Aboriginal ☐ Neither

☐ Yes – Torres Strait Islander ☐ Unknown

☐ Yes – both

Country of Birth:

Preferred Language:

Interpreter Required: ☐ Yes ☐ No

If yes, date/time of booking:

Reason for Admission/Relevant Health Issues:

Services Received Prior to Current Hospital Admission or Current Service Provider:

☐ Transition Care ☐ Respite Services ☐ Medication Supervision ☐ Palliative Care

☐ Personal Care ☐ Domestic Services ☐ Meals on Wheels ☐ Disability Services

☐ Mental Health Services ☐ HITH ☐ DVA Gold Card ☐ Home Care Package

☐ Transport ☐ Community Nursing ☐ Other:

Other Referrals Made (e.g. My Aged Care, ACAT, Home modifications):

Other Relevant Psycho-social Issues:

Services Requested (Case management included, services will be negotiated within the constraints of the package):

☐ Social Support ☐ Personal Care ☐ Meal Prep/or Meals on Wheels ☐ Transport ☐ Shopping

☐ Domestic Assistance ☐ Respite Care ☐ Medication Supervision ☐ Other:

Known WHS Issues/Risk Assessment (i.e. pets, substance abuse, violence history etc.):

Does the client require any equipment or review by health professional? If so how will this be provided?

Referrer Name: Contact Number:

Referrer Signaure: Print and Sign Designation:

Email: Referrer Facility:

Alternate Staff Contact: Alternate Staff Phone Number:

Client/Carer Signature Print and Sign Date: ____ / ____ / ______ Time: ____ : ____

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NH700270 150317

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