Out of Hospital Care Program
Referral Form

NSW GOVERNMENT

FACILITY/LHD:	*Complete all details or AFFIX PATIENT LABEL*
	FAMILY NAME:
	GIVEN NAME:
	DATE OF BIRTH: ☐ MALE ☐ FEMALE
Does the patient/person responsible consent to this referral: ☐ YES ☐ NO	**Address:**
	Telephone:
Location of patient (Home/Ward):	**MRN:**
Estimated Date of Discharge (for inpatients):	**Medicare No:**
Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown	**Country of Birth:**
	Residency Status:
☐ DVA Gold Card Holder ☐ Workers Compensation Claim ☐ Third Party Insurance Claim ☐ Other:	**Preferred Language:**
	Interpreter Required: ☐ Yes ☐ No **If Yes, Date/Time of booking:**
Spouse/Partner Name:	**Telephone:**
Emergency Contact:	**Telephone:**
Relationship to Client:	
GP Name:	**Telephone:**
Practice Address (or Suburb if known):	
Primary Specialist:	**Telephone:**

PACKAGE REQUIRED: ☐ ComPacks ☐ Safe and Supported at Home (SASH) ☐ End of Life (EOL)
☐ ComPacks/Healthy at Home *(SNSWLHD, SWSLHD, SESLHD, NSLHD and HNELHD only)*

For EoL Package ONLY:

Which palliative care phase is the patient currently experiencing:	☐ Deteriorating	☐ Terminal
Does the patient have an Advanced Care Directive (ACD):	☐ Yes	☐ No
Does the patient have a "Not for Resuscitation Order" in place:	☐ Yes	☐ No

Palliative Care Teams: What is the patient's Karnofsky Score?

NON-CLINICAL SERVICES REQUIRED:

☐ Case Management ☐ Personal Care ☐ Domestic Assistance ☐ Meal Preparation ☐ Shopping
☐ Transport to medical and other appointments ☐ Social Support ☐ Respite Care

Comments *(outline reason why services are required)*

HEALTH CONDITIONS *(include primary and secondary illnesses, reason for admission – if patient is in hospital)*

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Psycho-Social Disabilities *(mental health, anxiety, depression, other)*	
Sensory Disabilities *(vision, hearing, sensory processing, other)*	
CURRENT FUNCTION	
Mobility & Transfers *(use of walking aids, sitting, standing, transfers, falls risk)*	
Self-Care *(showering, bathing, shaving, washing hair, oral care, grooming, dressing/undressing, continence care if relevant)*	
Domestic Tasks *(meal preparation, shopping, cleaning surfaces, changing bedlinen, vacuuming, mopping and laundry)*	
SOCIAL SITUATION *(Include Family/Other Support)*	
Finances *(Salary/Wages, Superannuation, Centrelink Pensions/Benefits/Allowances, DVA Pension)*	
Accommodation *(own home, private rental, Housing NSW, other)*	**Transport** *(ability to drive, public transport, community transport, other)*
Risk assessment *(e.g. Access, Pets, Substance Abuse, Family Violence, Aggressive Behaviour, Hoarding, Squalor)*	

CURRENT SERVICES IN PLACE

☐ Community Nursing/HITH	☐ Palliative Care	☐ Chronic Care	☐ Mental Health
☐ CHSP	☐ Drug Health	☐ Allied Health	☐ HCP
☐ NDIS	☐ TACP	☐ STRCP	☐ DVA

Comments *(frequency and hours of service provision)*	
Service Provider Name:	**Service Provider Name:**
Contact Person:	**Contact Person:**
Telephone No:	**Telephone No:**

OTHER REFERRALS MADE:

☐ NDIS Reference No:	☐ Carer Gateway:
☐ My Aged Care Reference No:	☐ Other:

Referrer Name/ Position:	**Contact Number:**
Email:	**Referrer Signature:**
Alternative Referrer Name/Position:	**Contact number:**
Patient/Carer Signature:	**Date:**

Please attach any additional information such as the Patient Discharge Summary, Occupational Therapy Assessment, Physiotherapy Report and any other relevant material.