POST ACUTE CARE REFERRAL FORM

Referral to: ..... PAC

Fax: .....

Referral Date: |__|__|__|__|__|__|

Referring agency: .....

Referrers name: .....

Position: .....

Ward / Unit: .....

Tel: .....

Referral from:

- ☐ Acute Hospital
- ☐ Emergency
- ☐ Sub Acute / Rehab / GEM
- ☐ Hospice / Palliative Care
- ☐ Community

Attach Bradma label or complete details

Hospital UR #: .....

Name: .....

Address: .....

Suburb: .....

Tel: ..... **Postcode** .....

DOB: |__|__| |__|__| |__|__|__|__| **M / F**

Municipality:

Medicare Card Number:

If client is **NOT** being discharged to their usual address please specify:

Address: .....

Suburb: ..... Tel: .....

Hospital admission date: |__|__|__|__|__|__|

Hospital discharge date: |__|__|__|__|__|__|

First contact: .....

Address: .....

Relationship: .....

Home tel: .....

Mobile: .....

Primary Carer: Yes / No

Second contact: .....

Address: .....

Relationship: .....

Home tel: .....

Mobile: .....

Primary Carer: Yes / No

GP Name: .....

Address: .....

Tel: .....

Fax: .....

Cultural Information:

☐ Aboriginal / Torres Straight Islander

Religious affiliation: .....

Specific cultural requirements: .....

Country of birth: .....

Languages spoken: .....

Preferred language: .....

Is interpreter required for:

- ☐ Simple information
- ☐ Complex / medical information

Usual Living Arrangements:

- ☐ House
- ☐ Flat / Unit
- ☐ Boarding House
- ☐ Hostel / SRS
- ☐ Other. Specify: .....

- ☐ Owner
- ☐ Private Rental
- ☐ Ministry of Housing
- ☐ Homeless
- ☐ Other. Specify: .....

- ☐ Lives alone
- ☐ With spouse / partner
- ☐ With other person
- ☐ With other relative / children. Specify: .....

Safety / Access Issues:

Specify any issues about the discharge environment that may affect the care or safety of client, carer or service provider?

.....

.....

.....

.....

.....

Funding & Pension Status

- ☐ Pension Type: .....
- ☐ Workcover pending Claim #: .....
- ☐ TAC pending Claim #: .....
- ☐ DVA Entitlement Card Type: Gold / White Number: .....

POST ACUTE CARE REFERRAL FORM

Allied Health Assessments:

Please include a copy of relevant assessments.

- ☐ Social work — Name: ..... Tel: .....
- ☐ Physiotherapy — Name: ..... Tel: .....
- ☐ Dietitian — Name: ..... Tel: .....
- ☐ Speech Pathology — Name: ..... Tel: .....
- ☐ Occupational Therapy — Name: ..... Tel: .....

Attach Bradma label or complete details:

UR #: .....

Name: .....

DOB: ☐☐ ☐☐ ☐☐☐☐

- ☐ OT home assessment not required
- ☐ OT assessment - required & pending — Date ☐☐ ☐☐ ☐☐☐☐
- ☐ OT home assessment - completed — Date ☐☐ ☐☐ ☐☐☐☐

Reason for admission to hospital, health conditions and past medical history:

Social history / other comments:

Self Care Status at Discharge

	Independent	Assisted	Dependent
Mobility			
Transfers			
Stairs			
Bathing/Showering			
Dressing			
Toileting - bladder			
Toileting - bowels			
Medication			
Shopping			
Meal preparation			
Eating			
Laundry			
Banking/Bills			
Transport			

Physical & Mental Status at Discharge

Diet: .....

Chew / swallow: .....

Skin integrity: .....

Cognition: .....

Behaviour: .....

Mood: .....

Comprehension: .....

Speech: .....

Vision: .....

Hearing: .....

Mobility Aids:

POST ACUTE CARE REFERRAL FORM

Available family assistance:

Attach Bradma label or complete details:

UR #:

Name:

DOB:

Pre-existing Services . Please detail service type, frequency and agency providing service.

Case Manager: Agency: Tel:

New referrals to other agencies:

Please Include agency details and commencement date.

- ☐ Council / HACC services
- ☐ Home Nursing
- ☐ Community rehab / rehab in the home
- ☐ Community Health
- ☐ Palliative care
- ☐ ACAS
- ☐ Other

Services required under PAC Program:

Please detail specific service, task or need including suggested frequency

CLIENT AGREEMENT

I, (client name) agree:-

- to **participate** in the Post Acute Care program and
- that **information about my medical condition and care needs** can be supplied to the staff of the Post Acute Care program and may be discussed with services providing assistance to me, including my local doctor,
- that the post acute care staff may **feed back to the hospital staff** about my recovery and the care needed,
- That de-identified information can be forwarded to the Department of Health for the purpose of monitoring and evaluating the Post Acute Care program

SIGNED (Client) DATE

NON ENGLISH SPEAKING

If English is not my first language I acknowledge that the Post Acute Care program has been explained to me with the assistance of a qualified interpreter.

SIGNED (Client) DATE

If the client is unable to give informed consent a carer may sign on his/her behalf:

SIGNED RELATIONSHIP DATE