NSW GOVERNMENT | Health

Out of Hospital Care REFERRAL

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:**
Emergency Contact/Alternate Contact Name:	**Telephone:**
Relationship to Client:	
GP Name:	**Telephone:**
Practice Address (or Suburb if known):	
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

NON-CLINICAL SERVICES REQUIRED:

☐ Case Management ☐ Personal Care ☐ Domestic Assistance ☐ Meal Preparation ☐ Shopping

☐ Transport to medical and other appointments ☐ Social Support ☐ Respite Care

Comments:

HEALTH CONDITIONS: (For Inpatients - Reason for admission)

Interim

CURRENT FUNCTION

Mobility (Include falls risk statement)**:**

Self-Care:

Domestic Tasks:

Sensory Disabilities:

Psychosocial issues:

SOCIAL SITUATION (Include Family/Other Support):

Finances (Salary/Wages, Superannuation, Centrelink Pensions/Benefits/Allowances, DVA Pension):

Accommodation (Own Home, Private Rental, Housing NSW, other):

Risk assessment (e.g. Pets, Substance Abuse, Family Violence, Aggressive Behaviour, Hoarding, Squalor):

CURRENT SERVICES IN PLACE: ☐ Community Nursing/HITH ☐ Palliative Care ☐ Chronic Care ☐ Mental Health ☐ Drug Health ☐ Allied Health ☐ HCP ☐ CHSP ☐ TACP ☐ STRCP ☐ NDIS ☐ DVA

Additional Information:

Key Contacts:

OTHER REFERRALS MADE:

☐ NDIS Reference No: ☐ Carer Gateway

☐ My Aged Care Reference No: ☐ Other:

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

Interim