**IMPORTANT NOTICE - The information contained in this document is confidential. If you receive this message in error, please notify us immediately and return the original message to Silver Chain.**

**TELEPHONE Referrals (08) 9242 0347 Country 1300 300 122** Monday-Friday 9:00am - 5:00pm

**FACSIMILE Referrals 1300 601 788** Please fax each referral individually.

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| **CLIENT DETAILS** | | | **1st Visit Date** (nursing only)**:** | | | | Client Medicare No |
| Client URN |  | | | | | |
| Title | Given Names | | | | | | Surname |
| Address | | | | | | | Telephone |
| Suburb | | | | | | | Postcode |
| Email | | | | | | | |
| Date of Birth | | | | Next of Kin/Carer Name | | | Next of Kin/Carer Telephone |
| **To be completed if DVA client:** | | | | | | | |
| *DVA No* | | | | *Gold Card*  *White Card* | | *DVA GP/Hospital Provider No* | |
| **To be completed if privately funded:** | | | | | | | |
| *Name of Insurer* | | *Claim Number* | | | *Motor Vehicle*  *Workers Compensation*  *Private Health Cover*  *Hospital accepting payment* | | |

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| **REQUEST FOR** | |
| Nursing (including Clinic)  Access Home Care (Private Fee for Service)  Home Care Package (HCP) Level 2  Home Care Package (HCP) Level 4  Transition Care Package (TCP)  Case Management Services (Community Options)  *(Note: TCP and HCP require ACAT approval)*  **Hospice** or **Oxygen** available metro areas only - use designated Hospice or Oxygen Referral Form  **PEP referrals (only for hospital inpatients awaiting discharge)**  **Metro:** please phone 9242 0347 for verbal referral with the Allied Health Liaison. Mon – Fri 08:30-16:30  **Country**: please phone 9242 0347 to request, then fax, completed *Care Plan CC-FRM-007* | **Allied Health Services and other**  **Home Support Services (area specific)**  **Please phone Regional Assessment Service: 1300 785 415**  Physiotherapy  Podiatry  Home Independence Program (HIP)  Personal Care  Respite  Home Help  **Additional Services - Rural Locations Only**  Palliative  *(Priority referral)*  Support Service  Occupational Therapy  *Clinics:*  Oncology  Diabetic  Continence |

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| **CURRENT REFERRAL DETAILS *(To be completed for all referrals)*** | |
| Current Diagnosis/Surgery | Date |
| Goal of Care | |
| Treatment/Care Requested | |
| Relevant Medical and Social History | ACAT Approved?  Yes  No |
| Allergies/Impairments/Risk Factors? | |
| Discharge Summary Provided with Patient Yes  No | |

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| **REFERRAL PERSON/DEPARTMENT *(Complete where applicable)*** | | | | |
| Consultant Name | | | Phone Number | |
| Consultant Provider No | | | Fax Number | |
| Hospital | | Ward | Phone Number | |
| Hospital Provider No | | | Fax Number | |
| Client’s GP Name | | | Phone Number | |
| GP Provider No | | | Fax Number | |
| Name of person completing form | | | Date | |
| **CLIENT DETAILS *(From front page)*** | | | | |
| Title | Given Names | | | Surname |
| Address | | | | Telephone |
| Suburb | | | | Postcode |
| Email | | | | |
| Date of Birth | | | | URN |
| Discharge Summary provided with patient | | | | Yes  No |

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| **MEDICATIONS (including eye/ear drops, topical creams, nebulizers or suppositories**) | |
| I hereby authorise Silver Chain to administer the following medications to the above client commencing from - Date  (Medications must be listed below and signed by a Doctor) | |
| Doctor’s Name | Doctor’s Pager Number |
| Doctor’s Contact Phone Number | Date |
| Prescriber Number |  |

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| **Name of Medication** | **Dosage to be Given** | **Frequency** | **Route** | **Duration**  **(if applicable)** | **Doctor’s**  **Signature** |
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| Sealed Dose Administration Aid (SDAA)  Medications do not need to be listed, please indicate frequency | N/A |  | N/A | N/A |  |
| Special Instructions | | | | | |

When ordering medications:

***All medications will be given as per manufacturer’s instructions unless otherwise specified, ie IVABs.***

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| FACSIMILE 1300 601 788  Please fax each referral individually. **Thank you for your referral** Your referral will be processed and you will be notified of the outcome. |