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