PRESTIGE
inhome care

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Unit 32, 328
Reserve Road
Cheltenham
Victoria 3192
Australia
t 1300 10 30 10
f 1300 10 40 10

Eastern Office
110 Church Street
Hawthorn
Victoria 3122
Australia
t 9813 1933

Mornington Office
3/230 Main Street
Mornington
Victoria 3931
Australia
t 5973 6455

Geelong Office
130 Yarra Street
Geelong 3220
t 5222 8580

e info@prestigeinhomecare.com.au www.prestigeinhomecare.com.au

referral & enquiry form - Section 1

Enquiry taken by: Date 22/07/1 Time

Is this a general enquiry? ☐ Or, an actual referral for care? ☐

CLIENT DETAILS

Title Select… Other

Client Name

Address

Email

Phone Age/D.O.B

House ☐ Unit ☐ Lives alone? Select…

Is the client in hospital, or just being discharged? If so, which hospital?

Discharge Date 22/07/1

(Nursing referrals please also complete Section 2 (over page)

TYPE OF CARE

Limited Hours ☐ (< 10hrs per week)

Extended Hours ☐ (> 10hrs per week)

24 Hour Care Ad ☐

Hoc/once off ☐

DVA/NDIS #

Plan Date 22/07/18

Palliative ☐

Transport ☐

PCA ☐

Domestic ☐

Nursing ☐ (Please complete Section 2)

HGM ☐

Other Services Used

Private Provider ☐ Approved ☐

Council ☐ Allocated ☐

Home Care Package ☐

Ref code

Expiry date

FREQUENCY

Daily ☐ Weekly ☐ One Off ☐ W/E ☐ Fortnightly ☐

Duration (hours)

Requested Starting Time

Is client already home? Yes

Requested Start Date

Female ☐ Male ☐ Either ☐

STAFF

Detail any staffing preferences or necessary skills

HEALTH & SAFETY

Is the client mobile? N/A

Mobile aid used? No

Does the client display behaviours of concern? No

Vision Impairment No

Are there any identified risks? No

e.g Dogs, Unsafe Bathroom (Please attach supporting documents)

DOCTORS DETAILS

Name Provider No.

Clinic

Email address:

Phone Fax

CONTACT PERSON/NOK

Name

Mobile

Email

Relationship to Client

Is there a Power of Attorney? N/A

Is there an advanced directive? N/A

ACCOUNTS INFORMATION

Private ☐ Broker ☐ DVA ☐ Other ☐

Name/
Organisation

Contact Person

Email

Mobile

Address

Phone Fax

REFERRAL CONTACT INFORMATION (if applicable)

Referral contact name

Referral contact Telephone

Provider No. (if applicable)

Email

Signature

* Please be advised we may need to contact you for additional information if required.

MARKETING INFORMATION

How did you first find our phone/email address?

ADVERTISING
- Mail Drop ☐
- MAC ☐
- Yellow Pages ☐
- Word of Mouth ☐

INTERNET
- Google ☐ What word was searched?
- Facebook ☐
- Aged Care Online ☐
- Returning Client ☐

OTHER
- Medical Centre ☐
- Hospital ☐

referral & enquiry form - Section 2

CLINICAL INFORMATION

☐ Past medical history attached? (If not attached, please provide relevant medical history below e.g. Diabetes)

Known allergies? No

Details:

☐ Medications chart attached? (please ensure authorising Doctor's signature is visible where administration of medication is required)

☐ Supplies/Medication sent with client e.g. dressing/injection etc.

Number of days supplies provided

Wound chart/Current care plan attached? No

Supporting information/further details required to provide nursing care

☐ Attached (Discharge plan)

Follow up/Review plans e.g. future out-patient appointments/other services involved?

☐ Behavioural concerns