

referral & enquiry form - Section 1

Enquiry taken by: _____ Date _____ Time _____
Is this a general enquiry? _____ Or, an actual referral for care? _____

CLIENT DETAILS

Title _____ Other _____
Client Name _____
Address _____
Email _____
Phone _____ Age/D.O.B _____
House _____ Unit _____ Lives alone? _____
Is the client in hospital, or just being discharged? If so, which hospital? _____
Discharge Date _____

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

FREQUENCY

Daily _____ Weekly _____ One Off _____ W/E _____ Fortnightly _____
Duration (hours) _____
Requested Starting Time _____
Is client already home? _____
Requested Start Date _____
Female _____ Male _____ Either _____

STAFF

Detail any staffing preferences or necessary skills _____

HEALTH & SAFETY

Is the client mobile? _____
Mobile aid used? _____
Does the client display behaviours of concern? _____
Vision Impairment _____
Are there any identified risks? _____
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? _____
Is there an advanced directive? _____

ACCOUNTS INFORMATION

Private _____ Broker _____ DVA _____ Other _____
Name/ _____
Organisation _____
Contact Person _____
Email _____
Mobile _____
Address _____
Phone _____ Fax _____

TYPE OF CARE

Limited Hours (< 10hrs per week) _____
Extended Hours (> 10hrs per week) _____
24 Hour Care Ad _____ Palliative _____
Hoc/once off _____ Transport _____
DVA/NDIS # _____ PCA _____
Plan Date _____ Domestic _____
Nursing _____ (Please complete Section 2)
HGM _____

Other Services Used

Private Provider _____ Approved _____
Council _____ Allocated _____
Home Care Package _____
Ref code _____
Expiry date _____

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

INTERNET

Mail Drop

Google

What word was searched?

MAC

Facebook

Yellow Pages

Aged Care Online

Word of Mouth

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?

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?

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