BOLTON CLARKE Be true to you

The new face of RSL care + rdns

Referral to Bolton Clarke

At Home Support

Referrer: Please complete this form and fax it to Bolton Clarke as follows:

Melbourne: 1300 657 265; **Other Vic** (03) 5221 5541; **NSW** (02) 6584 5940; **QLD & Nth NSW:** 1300 792 129; **SA, TAS & WA:** 1300 768 296

This form is available from the 'Referrers' area in boltonclarke.com.au/referrals/ **Phone:** 1300 22 11 22

Client details:

(Attach adhesive label if appropriate)

Name:	**Bolton Clarke UR:** (if known)
Address: (Given name) (Family name)	
	Phone:
Date of birth:	**Gender:**
Next of kin/contact:	**Phone:**
Interpreter required: ☐ No ☐ Yes **Language spoken at home:**	
Diagnoses:	
Relevant past history:	
Allergies:	
Pension/DVA number: (if applicable)	
Client is aware of referral ☐ Yes ☐ No	
GP details if not referrer **Name:** _____ **Phone:** _____ **Address:** _____ **Fax:** _____ _____	

Referrer details:

(Complete as applicable)

Organisation/network: (e.g. Peninsula Health)	**The information has been faxed/phoned** ☐ Yes ☐ No
Hospital/facility:	**Ward/clinic:**
Referrer name:	**Phone:**
Email:	**Fax:**
Planned discharge date:	**Requested first visit date:**
GP/hospital DVA provider no.: (NOT client's VX number)	**ABN:**
Days you usually visit the client (Community referrers)**:**	

Referral to Bolton Clarke

Name:_____ UR: _____

At Home Support (continued)

Nursing care requested: (see below for home assistance)

(Tick as many as required)

- ☐ Nursing assessment
- ☐ Stomal therapy
- ☐ IV therapy⚠
- ☐ HIV/AIDS management
- ☐ Continence management
- ☐ Personal care
- ☐ Bowel management⚠
- ☐ Diabetes management⚠
- ☐ Urinary catheter management⚠
- ☐ Aged care
- ☐ Medication management⚠
- ☐ Palliative nursing care
- ☐ General nursing management
- ☐ Technical care⚠
- ☐ Pain management
- ☐ Wound management
- ☐ Other: (specify)_____

Additional information:

⚠ If you have requested an invasive procedure or medication (e.g. IV therapy, catheter management, wound care), please include or attach **medical authorisation** with details (e.g. medicine details, type and size catheter, specific wound regime). Please include information about infections (e.g. MRSA/VRE).

- ☐ Required equipment has been provided
- ☐ I have included/attached medical authorisation

Home assistance:

(Tick as many as required)

- ☐ Domestic assistance
- ☐ Transport
- ☐ Social support
- ☐ Respite
- ☐ Shopping
- ☐ Personal care
- ☐ Other: (specify)

Relevant information:

⚠ Please advise if there is any actual or potential risk to Bolton Clarke staff security.

Cognitive status:

Continence:

Mobility:

Hoist to be used by BC: ☐ No ☐ Yes **If yes, date of last service:** (Bolton Clarke staff will not be able to use the hoist unless it was serviced in the past 12 months.)

Client safety issues:

Carer:

At risk:

Access to home:

Other:

Other services involved or referred to:

Home Care Package: Organisation: **Package level:**

Case Manager: Name: Phone:

Community services ☐ Domestic assistance ☐ Respite ☐ Personal Care ☐ Home maintenance ☐ Other

Allied health: (specify)

ACAS/ACAT: (specify)

My Aged Care: Referred ☐ No ☐ Yes **RAS assessment:** ☐ No ☐ Yes **MAC ID:** if known

Transitional Care Prog:

Other: