

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

Melbourne and Vic: 1 300 657 265; **NSW** (02) 6584 5940; **QLD & Nth NSW:** 1300 792 129

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: <small>(if known)</small>
Address:	<small>(Given name)</small>	<small>(Family name)</small>	
			Phone:
Date of birth:			Gender:
Next of kin/contact:			Phone:
Interpreter required:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Language spoken at home:
Diagnoses:			
Relevant past history:			
Allergies:			
Pension/DVA number: <small>(if applicable)</small>			
Client is aware of referral	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
GP details if not referrer	Name: _____		Phone: _____
	Address: _____		Fax: _____

Referrer details:

(Complete as applicable)

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

Name: _____ UR: _____

Nursing care requested: (see below for home assistance) (Tick as many as required)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Nursing assessment | <input type="checkbox"/> Stomal therapy | <input type="checkbox"/> IV therapy [△] | <input type="checkbox"/> HIV/AIDS management |
| <input type="checkbox"/> Continence management | <input type="checkbox"/> Personal care | <input type="checkbox"/> Bowel management [△] | <input type="checkbox"/> Diabetes management [△] |
| <input type="checkbox"/> Urinary catheter management [△] | <input type="checkbox"/> Aged care | <input type="checkbox"/> Medication management [△] | <input type="checkbox"/> Palliative nursing care |
| <input type="checkbox"/> General nursing management | <input type="checkbox"/> Technical care [△] | <input type="checkbox"/> Pain management | <input type="checkbox"/> Wound management |
| <input type="checkbox"/> 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)

- | | | | |
|--|--|---|----------------------------------|
| <input type="checkbox"/> Domestic assistance | <input type="checkbox"/> Transport | <input type="checkbox"/> Social support | <input type="checkbox"/> Respite |
| <input type="checkbox"/> Shopping | <input type="checkbox"/> Personal care | <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Domestic assistance <input type="checkbox"/> Respite <input type="checkbox"/> Personal Care <input type="checkbox"/> Home maintenance <input type="checkbox"/> Other	
Allied health: (specify)	
ACAS/ACAT: (specify)	
My Aged Care: Referred <input type="checkbox"/> No <input type="checkbox"/> Yes RAS assessment: <input type="checkbox"/> No <input type="checkbox"/> Yes MAC ID: if known	
Transitional Care Prog:	
Other:	