Referral to Bolton Clarke Home and Community Support - HCS

Referrer: Please complete this form and fax it to Bolton Clarke: 1300 657 265
This form is available from the 'Referrers' area in www.boltonclarke.com.au/referrals/. **Phone:** 1300 22 11 22

Client details

Name:	Name (Given name) (Family name)	**Bolton Clarke UR:** (if known)	text
Address:	Enter text		
Address 2:	Enter text	**Phone:**	Enter text
Date of birth:	Enter text	**Gender:**	Enter text
Next of kin/contact:	Name Surname	**Phone:**	12345678
Interpreter required:	☐ Yes ☐ No	**Language spoken at home:**	Enter text
Diagnoses:	Enter text		
RELEVANT past history	Enter text		
Allergies:	☐ no ☐ yes - if yes specify: Enter text		
Client is aware of referral:	☐ no ☐ yes		
GP details: **IF NOT REFERRER**	**Name:** Enter text	**Phone:**	Enter text

Referrer details:

Complete as applicable

This information has been faxed/phoned: ☐ Yes ☐ No

Organisation/network:	Enter text (e.g. Eastern Health)		
Hospital / facility:	Name of hospital	**Ward/clinic:**	Ward name
Referrer name:	Name	**Phone:**	12345678
Email:	email@email.com.au	**Fax:**	22222222
Planned discharge date:	date	**Requested first visit date:**	date 2
GP/hospital DVA provider no:	number (not client's VX number)	**ABN:**	ABN (Community referrers)
Days you usually visit the client:	Days		

Home assistance

(Tick as many as required)

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

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Nursing care requested

(Tick as many as required)

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

Additional information: ⚠ Please include information about **infections** (e.g. MRSA/VRE) and a **medication summary**.

If you have requested an **invasive procedure** or **medication administration** (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).

Info

☐ Required equipment has been provided: text

☐ I have included/attached medical authorisation

Relevant information

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

On chemotherapy: Enter text

Cognitive status: Enter text

Continence: Enter text

Mobility: Enter text

Hoist to be used by BC: Enter text

Client safety issues: Enter text

Ward/clinic: Enter text

Phone: Enter text

Fax: Enter text

Current mental health supports? ☐ No ☐ Yes If yes list contact details – name, role, organisation, phone numbers below

Enter text

Carer: Enter text

At risk: Enter text

Access to home: Enter text

Advance care plan: Enter text

Please list any current documents.

Other (specify): Enter text

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Other services involved or referred to, including any other current or previous Bolton Clark services (i.e. retirement living, residential aged care or home and community support)

Support at Home: Organisation: Enter text

Case Partner: Name: Enter text Phone: Enter text

Community services: ☐ Domestic assistance ☐ Respite ☐ Personal care ☐ Home maintenance ☐ Other (specify): Enter text

Retirement Living? ☐ Yes. Name of facility: Enter text ☐ No

If yes, is it owned/operated by Bolton Clarke? ☐ Yes ☐ No

Allied Health: (specify) Enter text

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

Transitional Care Program: Enter text

Other: Enter text