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 *www.boltonclarke.com.au/referrals/*. **Phone:** 1300 22 11 22

Client details:

(Attach adhesive label if appropriate)

Name: _____ (Given name) _____ (Family name) **Bolton Clarke UR:** _____ (if known)

Address: _____

Address 2: _____ **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 appropriate)

Note: It is our practice to send GPs a brief letter notifying you of the client's primary nurse and the outcome of our initial assessment.

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

Hospital / clinic: _____ **Ward / unit:** _____

Referrer name: _____ **Phone:** _____

Fax: _____

Planned discharge date: _____ **Requested first visit date:** _____

GP/hospital DVA provider no: _____ (This is NOT the client's VX number)

Days you usually visit the client (Community referrers)**:**

Nursing care requested (see page 2 for home assistance):

(Tick as many as required)

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

Additional information:

⚠ If you have requested an invasive procedure (e.g. IV therapy, catheter management, wound care), please include or attach **medical authorisation** with details (e.g. 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.

Name: _____ Birth date: _____

Home assistance:

(Tick as many as required)

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

Medical authority to administer medicines:

(If hand writing, please print clearly, and print form to sign before faxing to us)

Medicine (Generic name where possible)	**Dose**	**Strength**	**Frequency**	**Route**

Doctor's name (print): **Signature:** **Date:**

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: _____