



**AVAILABLE 24 HOURS A DAY 7 DAYS A WEEK**  
**Telephone (08) 9242 0257 to confirm acceptance prior to faxing on (08) 9444 7265**

Post Acute

<b>CLIENT DETAILS (attach label if applicable)</b>		1 <sup>st</sup> Visit Date
Full Name:		1 <sup>st</sup> Visit Time
Address:		
Telephone:		Date of Birth:
Carer Details – Name:		Telephone:
Medicare Number:		URN:

<b>Relevant Medical, Surgical and Social History</b>

**REFERRAL DETAILS**

Diagnosis:	Date:
<b>Treatment/Care Plan (Treatment, Expected Duration and Follow-up Required)</b>	
Has the first dose been given? <input type="checkbox"/> Yes <input type="checkbox"/> No	Time given:
Is the Client on Warfarin <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage in mg (last given)
Consultant Name:	Contact Number:
Doctor Responsible for Medical Governance:	
Contact Number (24/7):	

<b>PATIENTS CURRENT GP DETAILS</b>		
Name:	Telephone:	
<b>PICC Line Details</b>	Type	Date Inserted:
External Length:	Certified to Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**REFERRER DETAILS (Person completing the form)**

**Name:** \_\_\_\_\_ **Hospital:** \_\_\_\_\_

**Contact Number:** \_\_\_\_\_ **Ward:** \_\_\_\_\_

<b>CLIENT DETAILS (attach label if applicable)</b>
Full Name:
Telephone:

<b>ALLERGIES:</b>

<b>MEDICATIONS:</b>

Date	Medication (Please Print) Tick if variable dose <input type="checkbox"/>	Time												
Route	Dose	Frequency	Time											
Prescriber Signature			Print Name				Provider No							

Date	Medication (Please Print) Tick if variable dose <input type="checkbox"/>	Time												
Route	Dose	Frequency	Time											
Prescriber Signature			Print Name				Provider No							

Date	Medication (Please Print) Tick if variable dose <input type="checkbox"/>	Time												
Route	Dose	Frequency	Time											
Prescriber Signature			Print Name				Provider No							



**CLIENT CONSENT**

I \_\_\_\_\_(print name) have had the “Silver Chain Hospital at Home or Post Acute Service” medical treatment and the possible side effects have been explained to me to my satisfaction and I agree to be medically managed in my own home.

I understand that my personal health information may be discussed between health care professionals directly involved with my care including my General Practitioner.

Comprehensive assessment may involve a photograph of a wound and subsequent photographs to monitor progress. Any photos will be stored in my Silver Chain medical records and strict confidentiality will be maintained. I consent to such photographs provided the above conditions are maintained and that my agreement is sought prior to taking the photo.

Photographs of a wound or procedure can be a valuable tool for staff education. Confidentiality is assured as all identifying features are removed. I agree to such photographs being used for education purposes.

I agree to co-operate with the Silver Chain service. I understand times may vary and I will be available at a time specified by the Nurse.

I agree that care will be transferred to other services as required.

I agree that if, in the opinion of the Silver Chain team, it is deemed necessary for me to be re-assessed in hospital, an ambulance will be called.

**Signature of Client or Legal Guardian:** \_\_\_\_\_

**Relationship to Client if Legal Guardian:** \_\_\_\_\_

**Witnessed By:** \_\_\_\_\_

**Date:** \_\_\_\_\_