**FAX to 1300 601 788**

**Please check ALL fields are completed.**

**Date:**

**Referrer Details:**

|  |  |
| --- | --- |
| Medical Practitioner Name (Please priont clearly)  Is this medical practitioner accepting clinical governance? Yes / No |  |

|  |  |
| --- | --- |
| **Name of Organisation/Facility:** | |
| **Provider Number:** | |
| **Referrer/Facility Street Address:** | |
| **Suburb:** | **Postcode:** |
| **Telephone:** | **Fax:** |
| **Email:** | |
| **Referrer/Facility** **Contact Person:** | |
| **Signature:** | |

**Client Details** (Please print clearly)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: | | Surname: | | | |
| Unit No: | Street No: | Street Name: | | | |
| Suburb: | | Postcode: | | | |
| Date of Birth: | | PID [if known]: | | | |
| Telephone: | | Male | | | Female |
| Living Arrangements:  Lives alone  With family  With others  Not stated | | | | | |
| Name of Carer [if applicable]: | | | | | Telephone: |
| Name of Next of Kin | | | | | Telephone: |
| Country of Birth: | | | Preferred Language: | | |
| Pensioner **or**  Health Care Card number:       Exp date: | | | | | |
| Please Note: Commonwealth Seniors Health Care card is not accepted for this service | | | | | |
| Is the client Aboriginal or/and Torres Strait Islander? | | | | Yes  No | |
| Is client permanent resident of WA = six months or more? | | | | Yes  No | |
| Has client had chronic incontinence for = six months or more? | | | | Yes  No | |
| Is the client receiving an NDIS package? | | | | Yes  No | |
| Is client receiving a Home Care Package level 1 - 2? | | | | Yes  No | |
| Is client receiving a Home Care Package level 3 - 4?  **If answer is yes, client inelgible for service.** | | | | Yes  No | |
| Does the client reside in a residential aged care facility?  **If answer is yes ,client inelgible for service.** | | | | Yes  No | |
| Does client have dementia or other cognitive impairment? | | | | Yes  No | |
| Is there any concerns with client communicating via telephone? | | | | Yes  No | |
| Is the named Next of Kin or Carer best to communicate on client’s behalf? | | | | Yes  No | |
| Name and contact details for Next of Kin /Carer | | | |  | |

|  |
| --- |
| Reason for Referral: |
| Current Medical Summary including medical and surgical history attached?  Yes  No  Please attach any relevant Urology/Urogynaecology or Gynaecaology communications. |
| Current medication list including allergies attached?  Yes  No |

**CMAS Eligibility Criteria**

* Aged over 16 years.
* Holder of Pensioner Concession Card ( Not Seniors card) OR Health Care Card.
* Chronic bladder or bowel problem for six months or longer.
* Permanent resident of Western Australia for at least 6 months.
* **NOT** in Receipt of a Home Care Package Level 3 or 4

Fax referral to 1300 601 788.

**Following Receipt of Referral**

A CMAS Resource Co-ordinator will contact your client for eligiblity screening and arrange an appointment. A letter will be sent addressed to the client confirming the appointment.

CMAS is funded by the West Australian Government and is delivered by Silver Chain.

For enquiries call the Continence Management and Advice Service (CMAS) on 1300 787 055.