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| --- | --- | --- |
| DOB |    | PID Number |
| Gender |   |   |
| Title |   | Surname |   |
| Given Names |   |
| Address |   |
|  | *(Type or affix sticker)* |

**Referral phone line 1300 300 122 is available for enquiries 24/7**

Please provide all relevant referral information for eligibility screening. A Silverchain nurse will call if further information or clarification is required.

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| REFERRER DETAILS |
| Hospital:       | Ward:       |
| Referrer name:       | Referrer phone:       |
| Referrer role:       | Referrer email:       |
| Treating doctor’s name:       | Contact number:       |
| Treating doctor’s speciality:       | Signature:       |
| *The treating doctor declares the client is medically suitable for discharge and not discharging against medical advice.* |
| Doctor Responsible for Medical Governance (if applicable):      Contact Number (24/7):       |

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| **CLIENT DETAILS** |
| Given name(s):       | Surname:       |
| Address:       |
| Telephone:       | Date of Birth:  |
| Email:       |
| Medicare Number:       Ref:       | URN:       |
| Next of Kin (NOK)/Carer Name:  | NOK Phone:       |
| Usual GP:       | GP Phone: |

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| **REFERRAL DETAILS** |
| **Presenting Complaint/Diagnosis:**  |
|       |
| **Hospital admission dates:** |
| Admission date: | [Choose date] | Surgery date:(if applicable) | [Choose date] | Discharge date: | [Choose date] |
| **Surgery details (if applicable)** (including any complications during admission and infection status)**:** |
|       |

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| **Treatment requested** (care type, expected duration and follow-up required): |
| **IV Therapy**[ ]  IV antibiotics[ ]  IV iron infusion[ ]  IV hydration (hyperemesis <20 weeks)[ ]  Other IV infusion**Other non-IV medication**[ ]       | **Anti-coagulation Therapy**[ ]  LMWH (Clexane/other)[ ]  NOAC[ ]  Warfarin | **Wound and Drain care**[ ]  Wound care[ ]  Drain Tube care[ ]  NPWT [ ]  PICC/PORT/VAD care[ ]  Newly commenced insulin therapy[ ]  Newly commenced stoma care  | **Catheter care**[ ]  TOV (from ED)[ ]  TOV (Inpatient)[ ]  IDC/SPC support |
| Details of treatment requested: (For NPWT, please provide device details, wound type, size, and location)      |
| Start 1st visit date: | [Choose date] | First visit timeframe: | [ ]  AM [ ]  PM |
| **Relevant medical, surgical and social history** |
|       |
| **Allergies, impairment or risk factor details: (e.g. falls, vision, hearing, cognitive)** |
|       |
| Is the patient pregnant?[ ]  No [ ]  Yes gestation:       weeks (> 20 weeks will require discussion with Silverchain CNM, for acceptance) |
| **To be considered for the safety of visiting staff:** |
| [ ]  Yes [ ]  No History of aggression or violence[ ]  Yes [ ]  No History of inappropriate behaviour[ ]  Yes [ ]  No History of substance abuse[ ]  Yes [ ]  No Any other risks for home visiting (behavioural/social issues, domestic violence, infectious diseases)Details:       |
| Is the patient receiving any other community care services?[ ]  No [ ]  Yes (if yes, include HCP level)Details:       |

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| **TREATMENT REQUEST DETAILS** (complete relevant section only) |
| **FOR ALL REFERRALS:** |
| [ ]  **Attached latest pathology and/or radiology results as per** [**Silverchain Clinical Protocols**](https://silverchain.org.au/refer-to-us/clinical-protocols) |
| **FOR CLIENTS REQUIRING IV THERAPY:** |
| General[ ]  Silverchain Home Hospital Medication Order form is attached[ ]  IV route and device specified. Route:       Device:       Is IVC difficult to site? [ ]  Yes [ ]  No[ ]  First dose has been administered without contra-indicationFor IV Antibiotics[ ]  Yes [ ]  No If IV Antibiotics are required for >2 weeks, has an Infectious Disease Consultant reviewed the client? If No, client must have a review before discharged and ID follow-up arranged, and details provided[ ]  Yes [ ]  No Will you supply consumables/medications for the first visit if patient is discharged on aFriday >12pm, over a weekend or on a public holiday? (Silverchain can only order medications on business days)*Note: the cut-off time for ordering medication consumables (as above) is 12.00pm for next day delivery.*For IV Iron Infusions[ ]  Yes [ ]  No Client must be able to attend a Silverchain Clinic.[ ]  Yes [ ]  No Is the client symptomatic? If Yes, provide details in relevant medical history sectionFor IV Hydration[ ]  Yes [ ]  No Confirmed diagnosis of hyperemesis.[ ]  Yes [ ]  No Have oral antiemetics been used first? |
| **FOR CLIENTS REQUIRING ANTI-COAGULATION THERAPY (including pre- and post- surgical bridging):** |
| General[ ]  Silverchain Home Hospital Medication Order form attached[ ]  Indication/reason for anti-coagulation documented in relevant medical history     For DVT/PE[ ]  Details of DVT/PE. Size:       Location:       For pre- and post- procedure / surgical intervention bridging[ ]  Yes [ ]  No Will post-surgical bridging be required? [ ]  Yes [ ]  No Is the procedure a Day procedure? If no, a new referral will be required prior to discharge. Date of procedure: [Choose date] Details of procedure:      Anti-coagulation type to be administered: |
| [ ]  LMWH (Clexane/other) | [ ]  Warfarin | [ ]  NOAC |
| [ ]  Therapeutic [ ]  BridgingCommencement date:[Choose date]If to cease, date: [Choose date]Current weight:      kg | Target INR:      Latest INR:      Commencement date:[Choose date]Usual dose:      mg[ ]  Script for discharge attached | Type:      Cease date: [Choose date]Commencement date:[Choose date] |
| **FOR CLIENTS REQUIRING WOUND, DRAIN, NEW INSULIN OR STOMA CARE:** |
| General[ ]  Wound management plan attached.[ ]  Silverchain Home Hospital Medication Order form attached.Choose care to be provided |
| [ ]  PICC/PORT/VAD care | [ ]  Newly commenced insulin treatment | [ ]  Newly commenced stoma care |
| Device type:      Date inserted: [Choose date][ ]  Device safe to use report is attached.[ ]  PICC insertion details in wound management plan. | [ ]  Blood sugar levels stable for three consecutive days.[ ]  Patient has own glucometer machine.[ ]  Diabetic parameters details provided for escalation. | [ ]  Stoma consumables organised.[ ]  Stoma Support Plan is attached |
| **FOR CLIENTS REQUIRING CATHETER CARE:** |
| General[ ]  Reason for insertion including urological history provided in relevant medical history section. For TOV[ ]  Yes [ ]  No Is the client under the care of a Urologist for referral should the TOV fail? Urologist name and contact:      [ ]  Yes [ ]  No Is there hydronephrosis or abnormal renal function at the time of retention?[ ]  Yes [ ]  No Has there been recent bladder, urethral or prostate surgery? Provide bladder stretch details (if known) below.Details:       |