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

|  |
| --- |
| **REQUEST FOR** |
| *[ ] [ ]* Nursing (including clinic)*[ ] [ ]* Access Home Care (Private Fee for Service) | 1st visit date:       |

|  |
| --- |
| **CLIENT DETAILS** |
| Given name(s):       | Surname:       |
| Telephone:       | DOB:       |
| Address:       |
| Medicare No:       | Ref No:       | URN:       |
| Next of Kin (NOK)/carer name:      | NOK/carer telephone:      |
| **To be completed if client age >65 or >50 if ATSI** |
| Does the client have a Home Care Package (HCP)? *Yes [ ]  No [ ]  Unknown [ ]* HCP Level: *[ ] [ ]  Level 1 [ ] [ ]  Level 2 [ ] [ ]  Level 3 [ ] [ ]  Level 4* |
| **To be completed if client with Department Veteran Affairs (DVA):** |
| DVA no:      DVA card: *[ ] [ ]  Gold Card [ ] [ ]  White Card* | DVA GP/Hospital Provider No:       |
| **To be completed if privately funded:** |
| Name of insurer *(if applicable)*:       |
| Claim no:      Claim type:*[ ] [ ]  Motor Vehicle [ ] [ ]  Workers Compensation [ ]*  | Payment agreement:*[ ] [ ]  Payment of Service form**[ ] [ ]  Other*       |

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| --- |
| **REFERRER DETAILS** *(complete where applicable)* |
| Hospital:       | Ward:       |
| Treating doctor’s name:       | Telephone:       |
| Medical Governance name:       | Telephone:       |
| Usual GP name:       | Telephone:       |
| GP practice address:       | GP email:       |
| Name of person completing form:      | Date completed:       |

|  |
| --- |
| **REFERRAL DETAILS** |
| Diagnosis:       |
| Treatment/care requested: *(for wounds please advise when the dressing was last changed)*      |
| Relevant medical history:      |
| Allergies/impairments/risk factors: *(such as falls, vison, hearing, cognitive)*       |
| Clinical supporting documentation enclosed:[ ]  *Yes* [ ]  *N/A* Discharge/Health Summary[ ]  *Yes* [ ]  *N/A* Wound Management Plan[ ]  *Yes* [ ]  *N/A* Other:       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name and type of medication** | **Dosage to be given** | **Route** | **Frequency** | **Time to be given** | **Start date** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
| Dr’s name:       |
| Signature:  | Prescriber no:       |

**Please complete and fax individual referral to 1300 601 788**

**or email** **SCReferrals@silverchain.org.au**