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

**FAX to 1300 601 788**

**Please check ALL fields are completed.**

**Date:** select date

**Referrer Details:**

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

Name of Medical governance:

|  |  |
| --- | --- |
| **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?  If yes client is eligible for assessment only | | | | | | Yes  No |
| Is client receiving a Home Care Package level 1 - 2?  If yes client is eligible for assessment only | | | | | | Yes  No |
| Is client receiving a Home Care Package level 3 - 4?  If answer is Yes, client ineligible for service. | | | | | | Yes  No |
| Does the client reside in a residential aged care facility?  If answer is Yes, client ineligible for service. | | | | | | Yes  No |
| Has the client been seen by an external Continence Service other than Silverchain in the last 12 months? | | | | | | 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: | | | | | | |
| **If this client requires catheter care then a referral to community nursing needs to be made separately. www.silverchain.org.au/refer-to-us/western-australia/community-nursing** | | | | | | |
| Please attach current Medical Summary including medical and surgical history.  Please attach any relevant Urology/Urogynaecology or Gynaecaology communications. | | | | | | |
| Please attach current medication list including allergies. | | | | | | |

**CMAS Eligibility Criteria**

* Permanent resident of Western Australia
* Clients who have experienced long term bladder and or bowel problems.
* Hold a pensioner concession card or health care card.
* Not in receipt of a Commonwealth Home Support Program - Home Care Package level 3 or level 4
* Clients in receipt of a home care package level 1 and 2 are eligible for assessment only.
* Clients in receipt of a National Disability Insurance Scheme (NDIS) Package are eligible for assessment only.
* Clients in receipt of a National Disability Insurance Scheme (NDIS) have their continence supplies funded through this package.

Fax referral to 1300 601 788 or email SCReferrals@silverchain.org.au.

**Following Receipt of Referral**

Silverchain will contact the client directly to arrange an assessment. This may be either via phone/SMS/letter.

For enquiries call the Continence Management and Advice Service (CMAS) on 1300 650 803 and ask for the Clinical Nurse Manager.