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| Werribee Mercy Hospital Health Independence Program |  | **Referral Date:** 5/03/2020 **Phone:** 8754 3800**Fax:** 8754 3281 |

 Referral to

|  |  |  |
| --- | --- | --- |
| [ ]  Community Based Rehab[ ]  Pulmonary Rehab | [ ]  Continence Clinic [ ]  Falls and Balance Clinic | [ ]  Complex Care |

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|  Patient Details |
| Last/Family name: | First name: |
| Previous last name: | Sex: Choose an item. |
| Date of birth: | ATSI status: Choose an item. |
| Address: | Home telephone No.: |
| Suburb: | Mobile number: |
| Postcode: | Email: |
| NOK/Carer: |  Preferred contact method: |
| NOK relationship: |  Medicare no.: |
| NOK contact no.: | Pensioner/Concession/Health/DVA No.: |
| Alternative contact address\*if applicable  |
| Interpreter required: [ ]  Yes [ ]  No Specify language: |
| Previous Mercy patient: [ ]  Yes [ ]  No  | Mercy UR Number (if known):  |
| The patient has agreed to the referral and the sharing of their personal and health information with the health service [ ]  Yes [ ]  No  |
| **Recent hospital admission** \*if applicable  | N/A [ ]   | Admission date: Discharge date: |
| [ ]  Include the latest discharge summary including any handover from other professions |
| **Accommodation**: Choose an item.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Ownership**: Choose an item.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Living arrangements**: Choose an item.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Funding & Pension status**[ ]  Pension Type: [ ]  DVA Choose an item.[ ]  NDIS | Workcover: Pending [ ]  Approved [ ] Claim #:TAC: Pending [ ]  Approved [ ] Claim #: | Substitute Decision Maker: [ ]  Yes [ ]  No Name:EPOA: [ ]  Yes [ ]  No Name:EPOA Medical: [ ]  Yes [ ]  No Name: |

 Referrer Details

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer / Discipline: |   | Provider number: |  |
| Referring Hospital/Agency/Practice: |  | Ward/Unit: |  |
| Practice Address: |  |
| Suburb: |  |
| Postcode: |  | Phone No: |  |
| Email: |  | Fax: |  |
| Preferred method of communication: |  |

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| **Patient’s usual GP** (if not the same as referring doctor) |
| Name: |  | Clinic: |  |

 Case Management

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| Case Manager \*if relevant: | Phone: |
| Agency: | Mobile: |

 Reason for referral / Care Coordination or treatment goals

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Past medical / social history

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 Current medication [ ]  Medication List attached

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| --- | --- | --- | --- |
| Drug name | Ltd. elapse | Strength | Dose / frequency / special |
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 Clinical information

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| Allergies:  |
| Height (cm): Weight (kg): BMI: |

 Relevant investigation / test results

Please attach results as per the Statewide Referral Criteria for Specialist Clinics <https://src.health.vic.gov.au>

**If the required investigation/test results are not attached the referral will not be accepted by Mercy Health**

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 Additional medical history Additional social history

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| Home oxygen: [ ]  Yes [ ]  No  | Does the client provide care for others? |
| Continence: Bladder - [ ]  Yes [ ]  No Bowel - [ ]  Yes [ ]  NoFrequency/duration of problem:Previous continence assessment [ ]  Yes [ ]  No Assessed by: Approx. date:Requires: [ ]  General continence assessment [ ]  Pelvic Floor Physiotherapy [ ]  ISC Instruction  | ACAS Assessment: [ ]  Yes [ ]  No [ ]  Required Assessment outcomes [ ]  HLC/LLC [ ]  Respite/Permanent [ ]  Level 1 / 2 package [ ]  Level 3 / 4 package My Aged Care referral [ ]  Yes [ ]  No [ ]  Required |

 Other notes/services (in place or arranged on discharge *e.g. management to date, impact of the problem on the patient)*

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| Doctor’s signature: |  | Date: |  |

**Appointment details will be sent to referrer and the patient.**

**IMPORTANT NOTICE – PRIVILEGED AND CONFIDENTIAL MESSAGE**

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