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

Referral to

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| 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

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| 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  No  Frequency/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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