Werribee Mercy Hospital Health Independence Program	Mercy Health Care first	**Referral Date:** **Phone:** 8754 3800 **Fax:** 8754 3281

Referral to

☐ Community Based Rehab ☐ Pulmonary Rehab	☐ Continence Clinic ☐ Falls and Balance Clinic	☐ Complex Care

Patient Details

Last/Family name:	First name:
Previous last name:	Sex: Select
Date of birth:	ATSI status: Select Indigenous status
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 Select DVA card type ☐ 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:			

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

Case Management

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

Reason for referral / Care Coordination or treatment goals

Past medical / social history

Current medication ☐ Medication List attached

Drug name	Ltd. elapse	Strength	Dose / frequency / special

Clinical information

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

Additional medical history

Home oxygen: ☐ Yes ☐ No

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

Additional social history

Does the client provide care for others?

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)*

Doctor's signature: Date:

Appointment details will be sent to referrer and the patient.