Post Hospital Support Program
Referral Form

Ph 02 6295 8800 Fax 02 6295 8100

Community Options
GPO Box 3067 Canberra ACT 2601

Referrer may have had a pre-referral discussion (optional) with a Community Options coordinator prior to sending this referral:

Referral discussed with: ____________ Date of contact: ____________
(Community Options Coordinator)

CLIENT DETAILS:

Date: ____________

Full Name - Mr/Mrs/Ms: ____________

Address: ____________

____________ Postcode: ____________

Telephone: (H) ____________ (W) ____________ (M) ____________

Date of Birth: ____________ Age: ____________ Male or Female: ____________

Lives Alone? Yes ☐ No ☐ Specify ____________

Home Owner ☐ Private Rental ☐ Public Rental ☐ Other ____________

Name of contact person: ____________

Relationship to client: ____________ Contact Ph: ____________

Next of Kin or second contact: ____________

Relationship to client: ____________ Contact Ph: ____________

Income type: ____________ DVA: Yes ☐ (Card Colour) ____________ No ☐

Country of Birth: ____________ Aboriginal/TSI Yes ☐ No ☐

Method of Communication: ☐ Verbal English ☐ Verbal Non-English ☐ Non-Verbal Specify ____________

ACAT Assessment: YES ☐ NO ☐ Pending ☐ Date of ACAT Assessment: ____________

Reason for admission to hospital:

____

Relevant past medical history:

____

Any known infectious risk factors (MRSA, VRE, hepatitis, scabies etc)? ____________

Client's Name:

Type of support requested: (also specify frequency and anticipated length of support)

Did the client have any support services prior to hospitalisation? YES / NO If yes, please specify type(s) of support and service provider(s). Please also identify the level of informal care and support received by client.

Is this patient expected to return to independence during Community Option's post hospital support? YES / NO
If No, please provide referral details for ongoing support services.

Date of admission to hospital:

Discharge date:

GP:

PH:

Care Needs: Please indicate patient's level of function

Low (Level 1)	Moderate (Level 2)	High (Level 3)*
Minimal / Stand by	Assistance of 1	Assistance of 2

Bathing	Low ( )	Moderate ( )	High ( )
Dressing	Low ( )	Moderate ( )	High ( )
Eating	Low ( )	Moderate ( )	High ( )
Mobility	Low ( )	Moderate ( )	High ( )
Toileting/Incontinence	Low ( )	Moderate ( )	High ( )

* High (Level 3) requires more details

Has an OT Assessment been done in this current hospital admission? YES ☐ NO ☐
Please attach a copy of OT Assessment.
If no assessment available, please summarise any OT recommendations for this patient.

Client's Name:

Are there any assistive aids (i.e. shower chair, walking frame) in place prior to admission? YES / NO
If yes, give details.

Wound Care: If personal care is required, please give instructions on wound care in the shower.

Medication: Is medication prompting required? YES / NO
If Yes, give details.

Are there any cognitive/behavioural issues that may impact on service delivery? YES / NO
If Yes, give details.

Please state any additional information that could assist us to provide appropriate support/s for this client, such as any special requirements because of cultural background, religion, financial disadvantage, male / female Support Worker etc.

Signature of Referrer:

Referrer's Name and Position:

Ward / Hospital /Organisation

Contact Phone Number:

Fax:

Date

Email:

This consent authorises Community Options to use information in this referral for the purpose of planning, organising and delivering services, as requested.

Written Consent

From:

☐ Client ☐ Carer ☐ Guardian

Verbal Consent

From:

☐ Client ☐ Carer ☐ Guardian

Verbal Consent obtained by:

(Name)

Signature:

Date: