Post Hospital Referral Form

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

Referral discussed with: Date of Contact

CLIENT DETAILS: Date:

Full Name - Title:

Address: Postcode:

Email:

Telephone: (H) (W) (M)

Date of Birth: Age: Gender:

Lives Alone? **Yes** ☐ **No** ☐ Specify

Home Owner ☐ Private Rental ☐ Public Rental ☐ Other

Primary Contact: Client ☐ Other ☐ Specify:

Contact Details:

Next of Kin or second contact (required):

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:

Reason for admission to hospital:

Relevant past medical history:

Type of support requested:

Anticipated length of support:

Did the client have any support services prior to the hospitalisation? **Yes** ☐ **No** ☐ If Yes please specify the type(s) of support and service providers. Please also identify the level of informal supports received by client**.**

Is this patient expected to return to independence during Community Options post hospital support? **Yes** ☐ **No** ☐
If No, please provide referral details for ongoing support services (MAC/NDIS)

Date of admission to hospital:

Discharge date:

GP / SPECIALIST:

PH:

Care Needs: Please indicate the patients 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 additional details**

Has an OT Assessment been done in this current hospital admission? **Yes** ☐ **No** ☐
Please attach a copy of the OT Assessment.

Are there any assistive aids (i.e. shower chair, walking frame) in place? **Yes** ☐ **No** ☐ If Yes, please give details.

Wound care: If personal care has been requested please detail any wound acre requirements.

Are there any cognitive/behavioral issues that that may impact on service delivery? **Yes** ☐ **No** ☐ If Yes, please give details.

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

REFFERING AGENCY:

Name of person sending referral:

Signature of referrer:

Date:

Position

Ward/Hospital/Organisation:

Contact Phone:

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 the client/guardian (name):

Or

Client ☐ Guardian ☐

Verbal Consent
From (name):

Client ☐ Guardian ☐

Verbal Consent obtained by: (Name)

Signature :

Date:

Office Use Only:

Referral accepted YES ☐ ***NO*** ☐

Program:

Signature:

Date: