St Vincent's Hospital

Community Health Service
Level 3 the O'Brien Centre
390 Victoria St
Darlinghurst NSW 2010

To make a referral
Phone 8382 1450
Fax 8382 1997
Email orc@stvincents.com.au

Referral Form

Referred by ________________ **Contact no.** ________________________ **Relationship** ________________
Ward _______________ Hospital ___________________ MRN _______________ AMO ___________________
Admission date _________________ Discharge date ________________ Date of Referral __________________

Patient surname ________________________ **Given names** ______________________ **DOB / / M F**
Discharge address ____ Suburb _______________________
Phone Home ______________________ Mobile _______________________ Work _____________________
Country of birth _____________________ Language _________________________ Interpreter required Y N
Aboriginal Y N Torres Strait Islander Y N

Contact person or next of kin Name _________________________ **Relationship to client** ________________
Address ____ Suburb ___________________________________
Phone Home ______________________ Mobile _______________________ Work _____________________

GP ____________________________ **Phone number** ______________________ **Suburb** __________________
Is the GP aware of this referral Y N Is the patient aware of this referral Y N

Financial details
Medicare no _____________ Expiry / /
DVA Goldcard Y N No ________________
Pension Y N No ________________

Other Services _____________________________________
____
____
ACCR Y N Date approved / /
High lvl ☐ Low lvl ☐ Respite ☐ CACP ☐ EACHP/D ☐

Diagnosis/medical history (include any relevant details – comorbidities, allergies, test results, ADL management and treatment being received)

Medical/discharge summary and medication list attached? Y N N/A | Requested by Referral Officer Y N N/A
Allied Health summaries including home visit reports attached? Y N N/A

Service requested/patient needs (description of problem or issue)

Active Rehabilitation Goals:

H/O Falls ☐ Carer Burden ☐ Increasing frailty Commencement date for nursing referrals / /
Medication authority: requested ☐ Completed/attached ☐ N/A ☐
Authority to change IDC: requested ☐ Completed/attached ☐ N/A ☐
Authority to provide VAC/NPW Management: requested ☐ Completed/attached ☐ N/A ☐

Communication Impairment	Cognition	Mobility	Personal risk assessment
Speech Y N Hearing Y N Vision Y N Aids ___________________	Alert & Orientated Y N Confusion – New ☐ Old ☐ Deterioration ☐ Dementia Diagnosis Y N	☐ Independent ☐ Independent with aid ☐ Assist x1 or x2 ☐ Wheelchair ☐ Bed bound	☐ Verbally threatening ☐ Acts of aggression ☐ Sexual harassment ☐ Other ________________________
Social Lives alone Y N Carer Y N Carer lives w/ client Y N In hospital/away ☐ Relationship ______________	Accommodation Home owner ☐ Rental – private ☐ public ☐ Boarding House ☐ Unknown ☐ Other ___________________	Palliative care Y N End stage Y N Diagnosis _________________ _________________________	Continent Y N ☐ Urine ☐ Faeces Self Caring Y N