South West Healthcare

Discharge Support and Liaison Referral Form

Please complete the following referral form if you are referring a patient for any of the following subacute pathways at South West Healthcare:

- Transition Care Program (home based or bed based).
- Home with Supports (E.g. Care co-ordination: PAC/Complex Care)
- Inpatient Rehabilitation (Rehabilitation or GEM (Geriatric Evaluation and Management))
- GEM @ Home
- RITH (Rehabilitation In The Home)

Once received, a Discharge Support and Liaison Team member will contact you to discuss and arrange any further assessment required to determine the most appropriate rehabilitation program for the patient you are referring. Please ensure that patient has consented to sharing this information. Should you have any queries about the pro-gress of your referral please call: **5563 1594**
All mandatory fields must be completed for the referral to be accepted **(* indicates mandatory fields)**

Referrer Details

*Date form completed:___/___/___ EDD ___/___/___

*Name of referring facility……

*Name of referring Clinician……

*Role/ Position of referring Clinician:……

*Name of referring medical consultant……

*Current Ward name……

*Current ward telephone number……

Patient Details

*Surname of Patient:
*Given Names:
*Date of birth:
*Address:
*City/Suburb:
*Patient preferred telephone:
*Gender:
*Resus Status:

Attach a label

*Weight:

*Date admitted to referring facility:___/___/___

*Admission diagnosis/ Current presenting problem/ surgery date/ Relevant investigations:

*Past Medical History

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Form Continued……

*Is the patient Aboriginal or of Torres Strait Islander descent? ☐Yes ☐No

*Existing Case Manager/Care Co-ordinator:

*ACAS Assessment Status:

*Existing Support Services:

*Licence: ☐Y ☐N
*Currently Driving: ☐Y ☐N
*Recent Falls : ☐Y☐N

*Lives alone: ☐Y ☐N
*Lives with Family: ☐Y ☐N
*Lives with others: ☐Y☐N

Infection control alerts / screens:…….

MTDM Details

Name: ……..
Relationship to patient: ……..
Email: ……..
Home Phone: ……..
Mobile:……

Consent to discuss plans with NOK ☐ Y ☐ N

Premorbid Function (E.G. Mobility, ADL's, CADL's, medications, driving, aids) (Please Circle):

dADL's I S A …….. ……

cADL'S I S A ……..

Mobilising I S A Aid…… Distance?……

pADL's Bathing I S A Dressing I S A. Grooming I S A. ? Aid ……

Continent Urine / Bowels I S A ? Aid …… Toileting I S A ? Aid……

Current function

Mental Status Behaviour ……

Mobility/ Transfers: ?Aids ……

Personal Care: ? Aids ……

Nutrition/Swallowing: ……

Communication : ……..

Faecal and Urinary Continence……? Aid……

Specific Care Requirements: ……

……

Goals for program

Mental Status Behaviour ……

Mobility/ Transfers: ?Aids ……

Personal Care: ? Aids ……

South West Healthcare

Form Continued……

Nutrition/Swallowing: ……

Communication : ……..

Faecal and Urinary Continence…….? Aid……..

***Type of Services requires (Please select from below):**

☐ Inpatient Rehabilitation

☐ Geriatric Evaluation and Management

☐ Home Based Transitional Care Program

☐ Bed Based Transitional Care Program

☐ Home With Supports (Eg Care Coordination: PAC/Complex care)

☐ GEM @ Home

☐ RITH (Rehabilitation in the home)

☐ Unsure of which would best meet patient needs

Specific Care Requirements Ie services likely to require: ……..

……

……

……

Please include Home Visit Risk Screen for those requesting services

Thank you for completing this referral. Please make contact with the Discharge Support and Liaison Team to ensure that they have received the email.

Please attach a current medication list and any other relevant investigation results including pathology.

Please attach a Home Risk Assessment if referring for home with supports.

Email to Discharge Support and Liaison Team on discharge@swh.net.au