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Back to Life

REFERRER DETAILS			*Date of Referral*
Referrer Name		Last Name	
Position		Organisation	
Address			
Phone No.		Email	
Fax No.		HealthLink EDI	

PATIENT DETAILS			
First Name		Date of Birth	
Last Name		Gender	☐ Male ☐ Female ☐ Unstated
Address			
Home Phone		Email	
Mobile Phone		***Consent to referral***	☐ YES ☐ NO

ELIGIBILITY CRITERIA FOR PATIENT BEING DISCHARGED FROM HOSPITAL / REFERRAL REASON

1) ☐ **Yes, living with three or more chronic health conditions/comorbidities.**
2) ☐ **Yes, at risk of readmission to hospital after transitioning home.**
3) ☐ **Yes, would benefit from short term follow-up support.**
4) ☐ **The patient does not receive any package which already provides a comprehensive support service component (e.g., COMPAC, TRANSPAC, CHSP, HCP, NDIS, etc.)**

Key Issues Identified (e.g., no current supports at home, no community care supports in place, multiple follow-up appointments need to be organised, home environment may need review, new medications need to be filled, assistive equipment required, etc.)	

ADDITIONAL CLIENT INFORMATION

Country of birth			Main language spoken at home?	
Aboriginal	☐ YES ☐ NO	*(If needed- tick both)*	Communication support required? (Please provide details)	☐ YES ☐ NO
Torres Strait Islander	☐ YES ☐ NO			
Employment status	☐ Full-time ☐ Part-time ☐ Unemployed ☐ Benefits, please specify:			
Are there any risk factors we should be aware of when visiting the home/client?	☐ NO ☐ YES - please specify or attach existing risk assessment if available.			

ADMISSION INFORMATION

Hospital Name		Hospital Ward	
Ward Phone		Ward Fax	
Reason for Admission			

DISCHARGING DOCTOR / TREATING SPECIALIST			
Doctor's Title		Doctor's Phone	
First Name		Doctor's Fax	
Last Name		Doctor's Email	
Specialty		HealthLink EDI	

GP DETAILS			
Referrer Name		Last Name	
GP Practice			
Address			
Suburb		Post Code	
Phone No.		Email	
Fax No.		HealthLink EDI	

DISCHARGE PLANNING & POST DISCHARGE INFORMATION			
Planned Discharge Date		Planned Discharge Time	

Upon discharge will the client be able to manage independently for the next 48 hours	☐ Yes ☐ No If **NO**, provide details:
Does the client require any medication post-discharge?	☐ Yes ☐ No If **YES**, provide details:
Does the client require any equipment post-discharge?	☐ Yes ☐ No If **YES**, provide details:
Does the client require any review by a health professional or additional imaging/pathology?	☐ Yes ☐ No If **YES**, provide details:
Are there concerns that the client is not capable of making their own decisions?	☐ Yes ☐ No If **YES**, describe:
Are Guardianship/ Enduring powers of attorney in place?	☐ Yes ☐ No If **YES**, provide details:
Does the client have any supports to help at home?	☐ Yes ☐ No If **YES**, provide details:

ASSOCIATED DOCUMENTS

1) ☐ Yes, I have attached the Patient's Health Summary (if available)
2) ☐ Yes, I have attached the Patient's Discharge Summary (if available)
3) ☐ Yes, I have attached the Patient's Care Plan (if available)

OFFICE USE ONLY Date: ..... ☐ Accepted ☐ Referral not accepted, reason: .....