GIPPSLAND SOUTHERN
Health Service

GSHS Acute and Subacute Referral Form

INSTRUCTIONS

Please note: GSHS does not have rehabilitation/GEM beds.

Instructions for completing form

- Please complete all sections and pages of referral form
- Please fax referrals to appropriate site.
- If client is happy to be referred to either campus, please ensure form is faxed to both.
    - Korumburra campus
        - Phone (03) 5654 2753
        - Fax no (03) 5654 2769
    - Leongatha campus
        - Phone (03) 5667 5669
        - Fax no (03) 5667 5626

- Referrals will not be accepted if form is incomplete
- Please ensure all appropriate documents are attached to referral
- Should you have any questions please don't hesitate to call

GIPPSLAND SOUTHERN Health Service

Acute and Subacute Referral

(Place Patient Label Here)

Unit Record No _____
Surname _____
Given Name _____
Address _____
Phone _____
D.O.B _____ Sex _____

Referrer's Details

Hospital/Agency:_____ Date of Referral:_____

Ward/Unit:_____ Contact Person:_____

Contact Phone:_____ Fax:_____ Email:_____

Reason for Referral:_____

Referral Type: ❑ Acute ❑ Palliative Care ❑ Maternity ❑ Maintenance Care

When will patient be ready for transfer? ❑ ASAP ❑ Within a week ❑ Within a month ❑ More than a month

Diagnosis/Medical History:_____

_____

_____

Past Medical/Psych History:_____

_____

_____

Treatment Plan: :_____

_____

_____

Allergies/Sensitivities/Reactions:_____

Do they have private health insurance? ❑ No ❑ Yes – details:_____

Does this person need rehabilitation? ❑ No ❑ Yes – details:_____

Does this person need maintenance care? ❑ No ❑ Yes – details:_____

Does this person need nursing home care? ❑ No ❑ Yes – details:_____

Infection Control

Does the patient exhibit:

- ❑ Copious drainage from a wound or abscess
- ❑ Diarrhoea
- ❑ Incontinence of bowel
- ❑ Skin shedding lesions
- ❑ Urinary catheter
- ❑ Uncontained sputum/urine
- ❑ Non-compliance with infection control practices
- ❑ Immunosuppression
- ❑ Invasive devices
- ❑ Was recently overseas in a country with endemic multi resistant organisms

Client Details

Country of Birth:_____ Language spoken at home:_____

Next of Kin's Name:_____ NOK's Phone:_____

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(Place Patient Label Here)

Unit Record No _____
Surname _____
Given Name _____
Address _____
Phone _____
D.O.B _____ Sex _____

Skin Integrity

❑ Intact ❑ Broken – if "broken" location:_____
Aetiology:_____
Current management:_____
Wound swab results:_____
Pressure injury grade: ❑ 1 ❑ 2 ❑ 3 ❑ 4

Social/Family Supports

Lives with: ❑ Alone ❑ Family ❑ Friends ❑ Attendant ❑ Other_____
Supports: ❑ Meals on Wheels ❑ Home Help ❑ Carer ❑ Community/DNS/Private Nursing
❑ Other_____ ❑ Case Manager Name:_____
Comments:_____

Elimination

Urine: ❑ Continent ❑ Incontinent ❑ Catheter ❑ Suprapubic Catheter
❑ Nephostomy ❑ Ileal Conduit ❑ Other_____
Bowel: ❑ Continent ❑ Incontinent ❑ Colostomy ❑ Ileostomy ❑ Suppositories/aperients
Aids used:_____ Incidents/accidents in past fortnight:_____

Functional Status

Weight Bearing: ❑ Non weight bearing ❑ Touch weight bearing ❑ Partial weight bearing
Rationale/Length of time: _____
❑ Weight bear as tolerated ❑ Full weight bearing

Transfers:	Bed mobility:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
	In/out of bed:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
	In/out of chair:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
	Mobility:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent

Aids:_____ Endurance: ❑ <17m ❑ >50m
Has own equipment: ❑ Yes ❑ No

Activities of Daily Living:

Grooming:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
Bathing:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
Dressing: Upper body:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
Dressing: Lwr body:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
Toiletting:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent

Other functional matters: _____
Falls history: _____
Current falls risk rating: _____
Medication list: _____
Pain: ❑ Acute ❑ Chronic
❑ Palliative – describe management plan: _____

(Place Patient Label Here)

Unit Record No _____
Surname _____
Given Name _____
Address _____
Phone _____
D.O.B _____ Sex _____

Cognition/Behaviour

Short term memory:	❑ Impaired	❑ Not impaired
Insight:	❑ Impaired	❑ Not impaired
Confused:	❑ Yes	❑ No
Comprehension:	❑ Impaired	❑ Not impaired
Expression:	❑ Impaired	❑ Not impaired
Social Interaction:	❑ Impaired	❑ Not impaired
Problem solving:	❑ Impaired	❑ Not impaired
Wandering:	❑ Yes	❑ No
Restless/Agitated:	❑ Yes	❑ No
Psychosocial Issues:	❑ Yes	❑ No

Mini mental score: _____

Comment on capacity to improve: _____

Nutrition

Weight:_____ BMI:_____ Malnutrition Score (MST): _____

Dietitian Referral Sent: ❑ No ❑ Yes – status_____ Report attached ❑ No ❑ Yes

Feeding: ❑ Independent ❑ Supervised ❑ Assisted ❑ Dependent

❑ Enteral feeding attached ❑ N/A ❑ Yes ❑ No reason_____

❑ Modified food/fluids specify:_____

Speech

Referral Sent: ❑ No ❑ Yes – status_____ Report:_____

Normal Swallowing ❑ Yes ❑ No – reason_____

No difficulties with understanding language ❑ Yes ❑ No – reason_____

No difficulties communicating with others ❑ Yes ❑ No – reason_____

Special Needs

❑ Hearing Impaired ❑ Vision impaired ❑ Literacy

❑ Haemodialysis ❑ IV Therapy ❑ Bariatric ❑ Pressure equipment

❑ Oxygen ❑ Palliative care

❑ Other (braces, splints, prosthesis)_____

❑ Dressings_____

(Place Patient Label Here)

Unit Record No _____
Surname _____
Given Name _____
Address _____
Phone _____
D.O.B _____ Sex _____

Follow Up Tests/Appointments

Date	Time	Test/Appointment	Location

Long-term Plan (✓ if applicable)

ACAS referral sent: ❑ Yes ❑ No
ACAS in progress: ❑ Yes ❑ No
ACAS complete: ❑ Yes ❑ No

❑ Yet to be determined
❑ Respite care
❑ Supported residential service
❑ Residential care
❑ Home independently / services / carer
❑ Hospice
❑ Transitional care program – home based
❑ Transitional care program - residential

Other

❑ Enduring power of attorney / administrator / guardianship / substitute decision maker
❑ No ❑ Required ❑ Pending ❑ Yes

Name and contact details:_____
_____

End of life plan/Advance care plan complete? ❑ Yes ❑ No
Attached: ❑ Yes ❑ No

Is the client aware of this referral? ❑ Yes ❑ No
If "no", why?_____

Campus for admission:

❑ Korumburra ❑ Leongatha
❑ Either (Please identify preference): _____

IMPORTANT:

Please attach copies of:
❑ Medication chart
❑ Recent pathology / radiology reports
❑ Allied Health Transfer letters
❑ Signed patient consent (Maintenance Care only)
❑ Other (please list) _____

Name of person completing this form:_____ Tel No:_____

Signature:_____ Date:_____

THANK YOU

****Please complete next page for all maintenance referrals*

ACUTE/SUBACUTE REFERRAL MR 020

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GIPPSLAND SOUTHERN Health Service

Korumburra campus
Phone: 5654 2753
Fax no: 5654 2769

Leongatha campus
Phone: 5667 5669
Fax no: 5667 5626

(Place Patient Label Here)

Unit Record No _____
Surname _____
Given Name _____
Address _____
Phone _____
D.O.B _____ Sex _____

Patient information re MAINTENANCE CARE at Gippsland Southern Health Service

Dear Sir/madam,

Your current clinicians have recommended that you continue your care under our "maintenance program".

This program aims to prevent deconditioning whilst you wait for any of the following:

- Build up confidence to return home with or without home services.
- Await an Aged Care Assessment
- Await an Aged Care Placement
- Your clinical condition although stable prevents you from commencing a GEM/ Rehabilitation program eg post surgery and waiting for bone healing before starting an intensive rehabilitation program.

The program aims to promote Activities of Daily Living (ADL'S), so it is expected that you will dress every day and participate in activities that represent ADL's.

Please note, this is **not** a rehabilitation program but initially you will be assessed by Allied Health Professionals who will set up a plan in conjunction with yourself and significant others such as family and care staff. With your consent and cooperation care staff will implement the plan daily with only intermittent follow up with Allied Health staff.

If your doctor is from Leongatha or Korumburra it is appropriate that they continue your care at the relevant campus.

In order for you to come on the program you must be in good health with no acute issues such as an infection (clinically stable) so please be sure there are no issues that still need to be dealt with by your current doctor. There will need to be a handover from your current doctor to the receiving doctor and he must be satisfied of your level of medical stability before you can be admitted.

If you have any follow up appointments at another facility that you are able to arrange transport to attend post admission. The other option is that the appointment can be conducted over teleconference or eHealth. This will reduce costs and inconvenience to all parties involved.

If you have any questions, please call any of the above numbers. We ask that you sign this document to ensure your understanding of the program and ask your current ward staff to fax back.

Signature_____Print name _____

Date _____

Thank You

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