GIPPSLAND SOUTHERN Health Service

Acute and Subacute Referral Form

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

GSHS provides care in a **low- to moderate-acuity setting**, suited to individuals who are clinically stable and not requiring additional resources such as on-site security or high-acuity medical support. We kindly ask that referrals align with this care environment to ensure the best outcomes for all patients.

Please email referral to AHC.Leongatha@gshs.com.au and call the Deputy Director of Nursing on 03 5667 5546 or After-Hours Coordinator on 03 5667 5669.

Referrals are reviewed by the GSHS team, and once accepted, the Deputy Director of Nursing (DDON) or After-Hours Coordinator (AHC) representative will contact the referring facility regarding next steps and transfer timing.

Note: This is the process for referrals to both campuses- Leongatha and Korumburra.

GSHS Referral Information – Acute / TCP / AOD / Maintenance Care / GEM / Maternity / Palliative

To support a safe and coordinated transfer, please note the following:

- We request a thorough medical handover from the referring Medical Officer/registrar to the GSHS medical team once the patient has been accepted.
- Transfers are best scheduled to arrive before 1800 hrs to allow time for orientation and settling in.
- GSHS offers **Maintenance Care** beds that support individuals who are clinically stable and require time to recover or are waiting for the next step in their care journey. This is distinct from Rehabilitation.
- GSHS offers a GEM and TCP program based at the Korumburra Campus.
- Please ensure all sections of the referral are completed to assist in timely review and decision-making. We require Physio and OT summary with goals to be completed with the referral.

We value your partnership in providing person-centred, coordinated care.

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DDON/AHC received referral:	
Date of received:	Time of Received:

MR020 ACUTE AND SUBACUTE REFERRAL FORM

IDENTIFY

Referrer/authorising practitioner Name:
Referring Facility:
Hospital Name:
Ward/Unit:
Contact Number:

Referral Type:
❑ Acute ❑ Palliative Care
❑ Maternity
❑ Maintenance Care ❑ AOD
❑ TCP ❑ GEM

Next of kin (NOK) / Carer
Name _____
Phone No _____
Relationship _____
NOK / Carer notified of transfer: ❑ Yes ❑ No

Transfer discussed with patient:
❑ Yes ❑ No
Date of transfer:

Allergies

SITUATION

Principal Diagnosis / Reason for transfer

Medical History / Co-morbidities

Faecal Continence ❑ Yes ❑ No Urinary Continence ❑ Yes ❑ No
Indwelling catheter ❑ Yes ❑ No Intermittent catheter ❑ Yes ❑ No
Stoma / Colostomy ❑ Yes ❑ No Falls Risk ❑ Yes ❑ No

Hearing Impaired ❑ Vision Impaired ❑ Mobility Aid required ❑ Cognitive impairment ❑

Height: _____ **Weight:** _____ **BMI:** _____

Functional Status:

Non-weight bearing ❑ Partial- Weight bearing ❑ Touch Weight Bearing ❑

Rationale & length of time: _____

Note: please discuss individuals with a BMI > 40 and limited functional ability with DDON / AHC to ensure our service can meet the safe and appropriate care needs of the consumer.

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BACKGROUND

Alerts – Bariatric Patient ❑ **Alerts** – Behaviours of concern ❑

Alerts – Pressure injury risk ❑

Advance Care Directives: ❑ Yes ❑ No ❑ Unknown

Goals of care ❑ **A** ❑ **B** ❑ **C** ❑ **D**

Social/Family Supports:

Lives: ❑ Alone ❑ Family ❑ Other: _____

❑ House ❑ Flat/Unit ❑ Aged Care Facility

❑ Other: _____

ASSESSMENT

Infections:

Is the patient currently being isolated with transmission-based precautions: ❑ Yes ❑ No

Does the patient have any infectious risks?

❑ MRSA ❑ VRE ❑ CPE ❑ ESBL ❑ Cdiff ❑ COVID

❑ Other _____

Treatment plan:

GSHS USE ONLY - COPY TO BE RETAINED FOR GSHS MEDICAL RECORDS

RESPONSIBILITY

Referral accepted: ❑ Yes ❑ No

Appropriate time of transfer agreed: ❑ Yes ❑ No Date: Time:

Acceptance by Receiving Bed Coordinator Name: _____

Date: Time:

Acceptance by Receiving Medical Practitioner: ❑ Yes ❑ No

Date: Time:

Receiving Medical Practitioner Name: _____

Patient Transport Provider Name:

Date & Time Booked:

Form completed by (print name & Position):	
Signature:	

Follow up Tests / Appointments

Date	Time	Test/ Appointment	Location

MR020 ACUTE AND SUBACUTE REFERRAL FORM