|  |
| --- |
|  **This form is to be completed by the Care Manager making the referral**  |
| **Referrer’s Name:**  | **Location:** | **Referral Date:** |
| **Referrer’s email:** | **Mobile:** |
| **Urgent**  | [ ]  **Yes *(specify why)***  | [ ]  **No**  |
| **Is there a previous nursing assessment**  | **Yes** [ ]  | **No** [ ]  |
| **Is there a current Consent form**  | **Yes** [ ]  | **No** [ ]  **(If no please obtain)** |
| **Referral Reason** |
| **HCP Clients Package Level** | [ ]  **Level 1** [ ]  **Level 2** [ ]  **Level 3** [x]  **Level 4** [ ]  **N/A**  |
| **Nursing Health Assessment** | **Initial** [ ]  | **Date client was accepted onto the HCP:** |
|  | **Review** [ ]  |
| **Package Supplements to be assessed** | [ ]  **None** [ ]  **Dementia and Cognition Supplement**  |
| **Wound Care *(Please specify wound location)*** |  |
| **Other services *(Please specify*)** |  |
| **NDIS**  | **Clients NDIS Number:** |
| **Services included in Budget** | **Diabetic supports** [ ] **Continence Supports** [ ] **Wound/Pressure Care** [ ] **Other (Please Specify)** [ ]   |
| **Client Details** |
| **Name:**  | **DOB:**  |
| **Home Address:** |  |
| **Contact person to schedule the appointment:** | **Contact Name:**  | **Relationship to client:**  |
| **Contact Phone Number:**  |
| **Is an Interpreter required** | [ ]  **Yes *(Please specify*)** | [ ]  **No** |
| **Other Comments:** *(i.e. health concerns, hospital discharge, dress code in the client’s home, diversity, allergies, medical considerations)* |  |
| **Any additional OHS risk/concerns in the home:**  | **The entry to the home is**  |

**Return to: nursing@communitygateway.net.au**