Referral to Bolton Clarke Home and Community Support - HCS

Referrer: Please complete this form and fax it to Bolton Clarke: 1300 657 265
This form is available from the 'Referrers' area in www.boltonclarke.com.au/referrals/. **Phone:** 1300 22 11 22

Client details

Name:	Enter text (Given name) (Family name)	**Bolton Clarke UR:** (if known)	Enter text
Address:	Enter text		
Address 2:	Enter text	**Phone:**	Enter text
Date of birth:	Enter text	**Gender:**	Enter text
Next of kin/contact:	Enter text	**Phone:**	Enter text
Interpreter required:	☐ Yes ☐ No	**Language spoken at home:**	Enter text
Diagnoses:	Enter text		
RELEVANT past history	Enter text		
Allergies:	☐ no ☐ yes - if yes specify: Enter text		
Client is aware of referral:	☐ no ☐ yes		
GP details: **IF NOT REFERRER**	**Name:** Enter text	**Phone:**	Enter text

Referrer details:

Complete as applicable

This information has been faxed/phoned: ☐ Yes ☐ No

Organisation/network:	Enter text (e.g. Eastern Health)		
Hospital / facility:	Enter text	**Ward/clinic:**	Enter text
Referrer name:	Enter text	**Phone:**	Enter text
Email:	Enter text	**Fax:**	Enter text
Planned discharge date:	Enter text	**Requested first visit date:**	Enter text
GP/hospital DVA provider no:	Enter text (not client's VX number)	**ABN:**	Enter text (Community referrers)
Days you usually visit the client:	Enter text		

Home assistance

(Tick as many as required)

☐ Domestic assistance	☐ Transport	☐ Social support	☐ Respite
☐ Shopping	☐ Personal care	☐ Other (specify):	

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Nursing care requested

(Tick as many as required)

- ☐ Nursing assessment
- ☐ Medication management ⚠
- ☐ Urinary catheter management ⚠
- ☐ General nursing management
- ☐ Technical care ⚠
- ☐ Other (specify): Enter text
- ☐ Stomal therapy
- ☐ Personal care
- ☐ Palliative nursing care
- ☐ Pain management
- ☐ Continence management
- ☐ HIV/AIDS management
- ☐ Diabetes management ⚠
- ☐ Aged care
- ☐ Wound management
- ☐ Bowel management ⚠
- ☐ IV therapy ⚠

Additional information: ⚠ Please include information about **infections** (e.g. MRSA/VRE) and a **medication summary**.

If you have requested an **invasive procedure** or **medication administration** (e.g. IV therapy, catheter management, wound care), please include or attach **medical authorisation** with details (e.g. medicine details, type and size catheter, specific wound regime).

Enter text

☐ Required equipment has been provided: Enter text

☐ I have included/attached medical authorisation

Relevant information

⚠ Please advise if there is any actual or potential risk to Bolton Clarke staff security.

On chemotherapy: Enter text

Cognitive status: Enter text

Continence: Enter text

Mobility: Enter text

Hoist to be used by BC: Enter text

Client safety issues: Enter text

Ward/clinic: Enter text

Phone: Enter text

Fax: Enter text

Current mental health supports? ☐ No ☐ Yes If yes list contact details – name, role, organisation, phone numbers below

Enter text

Carer: Enter text

At risk: Enter text

Access to home: Enter text

Advance care plan: Enter text

Please list any current documents.

Other (specify): Enter text

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Other services involved or referred to, including any other current or previous Bolton Clark services (i.e. retirement living, residential aged care or home and community support)

Home Care Package:	Organisation: Enter text		Package level: Enter text	
Case Manager:	Name: Enter text		Phone: Enter text	
Community services:	☐ Domestic assistance	☐ Respite	☐ Personal care	
	☐ Home maintenance	☐ Other (specify): Enter text		
Retirement Living?	☐ Yes. Name of facility: Enter text			
	☐ No			
If yes, is it owned/operated by Bolton Clarke?	☐ Yes ☐ No			
Allied Health: (specify)	Enter text			
My Aged Care:	Referred: ☐ Yes ☐ No	RAS assessment: ☐ Yes ☐ No	MAC ID: (if known)	
Transitional Care Program:	Enter text			
Other:	Enter text			