**Referral Form for Community Rehabilitation Services Richmond Network**

**Incorporating Day Therapy Services and Home Based Rehabilitation Service**

Suitable for clients from an **Inpatient Facility**

*\* Please forward this referral at least* ***2 days******prior to discharge home \****

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT DETAILS** | | | | | | | | |
| **MRN:** | |  | | **DOB:** |  | **GENDER:** | |  |
| **SURNAME:** | | |  | | | **FIRST NAME:** | |  |
| **ADDRESS:** | | |  | | | | | **CLIENT PH:** |
| **ABORIGINAL OR TORRES STRAIT ISLANDER:** **YES** **NO** **Not Identified** | | | | | | | | |
| **CARER/NEXT OF KIN:** | | | |  | | **RELATIONSHIP:** | |  |
| **ADDRESS:** | | |  | | |  | | **CONTACT PH:** |
| **GP:** |  | | | | | **GP PHONE: 🡪** | |  |
| **CURRENT SUPPORT SERVICES IN PLACE:** | | | | | | **COMPACKs** *(details):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Home Care Package-** Level 1 Level 2 Level 3 Level 4 *Waiting List for level*: \_\_\_\_\_\_   **Commonwealth Home Support Programme** *(details of service):*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **National Disability Insurance Scheme** *(details of current application status):*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **MEDICAL DETAILS** | | | | | | | | |
| **DIAGNOSIS/INJURY – DATE OF ONSET:** | | | | | | | | |
|  | | | | | | | | |
| **PRE-EXISTING CONDITIONS:** | | | | | | | | |
|  | | | | | | | | |
| **REASON FOR REFERRAL:** | | | | | | | | |
|  | | | | | | | | |
| **ESTIMATED DATE OF DISCHARGE:** | | | | | | | | |
| **Client requires:** Physiotherapy Occupational Therapy Social Work Speech Pathology  ***NOTE:******To be******eligible for the******Home Based Rehabilitation Service****,* ***2 disciplines are required*** *(above)* | | | | | | | | |
| **CLIENT ELIGIBILITY** | | | | | | | | |
| **For a person to be suitable for referral they must meet all the following criteria:** (please tick)  Medically stable Has the cognitive capacity to learn  Aware of referral and willing to engage Demonstrates a capacity for improvement  Currently an inpatient of an Acute / Rehabilitation service  Safe for discharge with appropriate services and equipment in place | | | | | | | | |
| **NOTE:** To be eligible for the **Day Therapy Service c**lients need to present with difficulties in **at least** **two of the following functional areas**: (please tick)   Mobility Communication difficulties Swallowing difficulties   Risk of Falls Psychosocial/emotional Wellbeing  Home Safety   Employment/Recreation/ Leisure  Activities of Daily Living e.g. feeding, personal care, domestic duties | | | | | | | | |
| **REFERRER INFORMATION** | | | | | | | | |
| **REFERRED BY:** | | | | | | | **SIGNATURE:** | |
| **DESIGNATION:** | | | | | | | **CONTACT NO:** | |
| **ORGANISATION:** | | | | | | | **EMAIL:** | |
| **DATE:** | | | | | | |

***\* Please provide a discharge summary, as soon as is available, as part of the referral process \****

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| **ALLIED HEALTH SUMMARY REPORTS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PHYSIOTHERAPY REPORT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Prior Mobility**: Walking aid | | | | | | | | |  | | | | | | | | Assistance required &  Distance : | | | | | | | | | | | |  | | | | | | | | | | | | |
| **Current Impairments:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current Function: Transfers:** | | | | | | | | | | | Lying to sitting | | | | | | | | |  | | | | | | | | | | | Sit to Stand: | | | | | | | | |  | |
| **Walking:** | | Aid | |  | | | | Assistance | | | | | | | | | |  | | | | | | | | | Distance | | | |  | | | | WB status | | | | | |  |
| **Objective Measures** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current Treatment**: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Print Name:** | | |  | | | | | | | | | | | | | Signature: | | | | | | | |  | | | | | | | | | Phone: | | | |  | | | | |
| **OCCUPATIONAL THERAPY REPORT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current Function:** | | | | | Upper Limb: | | | | | | | | | | | | | | | | | | | | | | | Cognition: | | | | | | | | | | | | | |
| P ADLs: | | | | | | | | | | | | | | | | | | | | | | | | I ADLs: | | | | | | | | | | | | | | | | | |
| Falls History **Y / N** | | | | | Pressure Care Issues **Y / N** | | | | | | | | | | | | | | | **Details:** | | | | | | | | | | | | | | | | | | | | | |
| Home Safety Concerns **Y / N** | | | | | | | | | | **Details:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other ongoing issues:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current equipment:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Equipment Review required **Y / N** | | | | | | | | | | | | |
| **Summary Intervention:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Supports in place post Discharge:** | | | | | | | | | | | | ComPacks **Y / N** | | | | | | | | | | | | | Other: | | | | | | | | | | | | | | | | |
| **Print Name:** | | |  | | | | | | | | | | | | Signature: | | | | | | | | |  | | | | | | | | Phone: | | | |  | | | | | |
| **SOCIAL WORK REPORT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has the client seen a Social Worker?  YES  NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date last seen**: \_\_\_/\_\_\_/\_\_\_\_ | | | | | | | | | | | |
| If **YES** a **Psychosocial Intervention Summary** is required to be attached | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client Lives:**  Alone  With Carer  Concerns for/about Carer  Disability support | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client linked with:** Neuropsychologist Mental Health Services Geriatrician NBIRS   Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client has received:**  ACAT Assessment  Lifetime Care & Support Authority Application  NDIS Application | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client has a history of:**  Drug/Alcohol Misuse  Violent/ Difficult Behaviours  Domestic Violence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Comments:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Print Name:** | | |  | | | | | | | | | | Signature: | | | | | | | | | |  | | | | | | | | | | | Phone: | | | |  | | | |
| **SPEECH PATHOLOGY REPORT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has the client been assessed by Speech Pathology?  YES  NO **Date last seen**: \_\_\_/\_\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Diet:**  Full  Soft  Minced and moist  Puree  Nil by Mouth | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Fluids:** Thin  Thickened (please circle): mildly moderately extremely | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nutrition/Swallowing or mealtime issues:** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **Speech and Language:**  Receptive: Normal Impaired Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expressive: Normal Impaired Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Print Name: | | |  | | | | | | | | | | | Signature: | | | | | | |  | | | | | | | | | | | | | Phone: | | | | |  | | |
| **CLIENT’S REHABILITATION GOALS:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. |  | | | | | | | | | | | | | | | | | | | | | 2. | | | |  | | | | | | | | | | | | | | | |
| 3. |  | | | | | | | | | | | | | | | | | | | | | 4. | | | |  | | | | | | | | | | | | | | | |
| **Preferred service: HBRS  or DTS  *NB:*** *Your preference will be considered in line with current service capacity.*  ***Reason for preference:*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Page 2 of 2**