MONASH HEALTH

POST ACUTE CARE REFERRAL

Community Access Email Address:
icareaccess@monashhealth.org

Phone: 8572 5631 **Reset Form**

UR:
Patient Name:
DOB:
Sex:
Address:

Mobile:
Email:

Contact should be made with: ☐ Client ☐ Emergency contact

☐ Client is aware of referral & verbal consent given?

☐ Patient Registration Form with patient demographics, GP and Next of Kin must be attached.

Admission Date (if applicable)		Estimated Discharge Date (if appliable):	

Discharge address (if different to Patient ID label):		Phone:
Emergency Contact Person:	Relationship:	Phone:

Diagnosis /
Reason for Admission:

Relevant Medical History:

Social History/Issue:

Communication	Physical Function	Social	Current Services	Risks
☐ No impairment	☐ Independent	☐ No identified supports	☐ Council	☐ Behavioural concern
☐ Hearing Impaired	☐ Requires prompting	☐ Lives alone	☐ Private	☐ Allergies
☐ Vision Impaired	☐ Requires Assistance	☐ Family/Friend support	☐ Home Care Package Level 1-2	☐ Chemotherapy
☐ Speech Impaired			☐ Level 3 - 4	☐ Clutter / home in disrepair
			☐ Case Manager details:	☐ Drug/Alcohol Dependence
				☐ COVID Positive Clearance Date
				☐ Other (eg. VRE)

☐ Risk management plan discussed with client and PAC

☐ If Level 3-4 package, have you liaised with Case Manager & reason why package cannot fund PAC service?

PAC Service Requested	Information required to process referral. Please attach with referral.	
☐ IDC Management	☐ Change of catheter form ☐ TOV Date	☐ Insertion Date ☐ Education / Support visits
☐ Wound Care ☐ Stoma Care	☐ Wound Chart & Frequency ☐ Signed Order	☐ 3 days products supplied ☐ Suture/clips removal date
☐ Collar/Brace Care	☐ Instructions provided	☐ PCA Summary attached
☐ Clexane administration	☐ Signed drug chart / medications / sharps container supplies given	☐ Process for dosing warfarin
☐ Insulin Administration	☐ Signed drug chart / medications / sharps container / reportable levels ☐ BSL reportable limit form	
☐ Medication Management	☐ Signed Drug chart	☐ Webster Pack
☐ Home Care	☐ Short-Term Service	☐ Ongoing
☐ Personal Care Assistance (PCA)	☐ PCA Summary attached ☐ Short-Term Service ☐ Ongoing	
☐ Shopping Assistance	☐ Short-Term Service	☐ Ongoing
☐ SRS Accommodation	☐ Recuperative – Plan for post SRC	
☐ Physiotherapy	☐ Physio discharge summary ☐ Referral to CRC	☐ Referral to CHS ☐ Referral to RITH

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My Aged Care Referral Completed: *(If applicable)* ◯ Yes ◯ No ◯ Not Applicable			MAC Referral No:	
☐ **MEDICAL DISCHARGE SUMMARY ATTACHED**				
***Referrals sent without required information will be returned to the referrer**				
Referrer Name:		Designation:		Date:
Hospital/Ward Name:		Contact Number:		

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