MONASH HEALTH

COMMUNITY REFERRAL FORM

Community Access Email Address:
icareaccess@monashhealth.org

Phone: 8572 5631

Reset Form

UR:
Patient Name:
DOB:
Sex:
Address:

Mobile:
Email:

Has the patient recently been hospitalised? (within 30 days?) ◯ Yes ◯ No

☐ Client is aware of referral & verbal consent given?

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

Urgency:	Please Select	Duration of presenting issue?	Please select
Admission Date (if applicable)		Estimated Discharge Date (if appliable):	
Discharge address: (if different to above)			Phone:
Indigenous Status: Disability:	Please select	Refugee / Asylum Seeker Status: Date of Arrival in Australia:	Please select
Interpreter required?	◯ Yes ◯ No	Preferred Language?	
COVID Positive?	◯ Yes ◯ No	Clearance Date:	
Home-visit required?	◯ Yes ◯ No	If no, how will client access clinic?	☐ Drive ☐ Taxi ☐ Other ☐ Family/ Friend ☐ Public Transport
Emergency contact person:		Relationship:	Phone:
Who is the primary contact for this referral?		Patient ◯	Carer ◯

Reason for Referral:
(include goals of care)

Ensure all text is visible prior to sending referral

Relevant Medical History:

Ensure all text is visible prior to sending referral

Social History/Issue:

Ensure all text is visible prior to sending referral

***Referrals sent without required information will be rejected and returned to the referrer. Please refer to** Referrals for Community-based services | Monash Health

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Communication	Physical Function	Social	Current Services	Risks
☐ No impairment	☐ Independent	☐ No identified supports	☐ Nil known	☐ Behavioural concern
☐ Hearing Impaired	☐ Requires prompting	☐ Lives alone	☐ Council	☐ Allergies
☐ Vision Impaired	☐ Requires Assistance	☐ Family/Friend support	Home Care Package Level	☐ Chemotherapy
☐ Speech Impaired	☐ Walks with Aids	☐ Vulnerable Housing	☐ Level 1-2	☐ Clutter/home in disrepair
☐ Cognitive impairment	☐ Wheelchair bound	☐ Risk of family violence	☐ Level 3-4	☐ Drug/Alcohol Dependence
	☐ Incontinent		☐ Private Services	☐ Other (eg.VRE)
	☐ Oxygen required		☐ NDIS Plan in place	

Hospital Admission Prevention Flags

☐ Difficulty swallowing / eating / maintaining nutritional needs	☐ Poor medication concordance	☐ Shortness of Breath	☐ Mental Health illness
☐ Unstable BSL	☐ Wound Breakdown	☐ Swelling ankles	☐ Not applicable

My Aged Care Referral Completed:
Patients over 65 (over 50 ATSI)
○ Yes ○ No ○ Not Applicable

MAC Referral No:

SERVICE REQUESTED

Complex Care (HARP)

- ☐ Heart Failure
- ☐ Respiratory
- ☐ Complex psychosocial needs

Sub-acute Specialist Clinics

- ☐ Cognitive Dementia & Memory Service
- ☐ Continence
- ☐ Falls & Balance
- ☐ Movement Disorder
- ☐ Pain Management (Refer to Statewide Referral Criteria)

Community Health

- ☐ Counselling
- ☐ Diabetes Clinic
- ☐ Dietetics
- ☐ Exercise Physiology
- ☐ Nursing Occupational Therapy
- ☐ Physiotherapy
- ☐ Podiatry
- ☐ Psychology
- ☐ Social Work
- ☐ Speech Pathology

Rehabilitation

- ☐ Cardiac Rehab
- ☐ Heart Failure Rehab
- ☐ Pulmonary Rehab
- ☐ Other Rehab

FUNDING INFORMATION:

Medicare Number:		☐ TAC	Number:
Medicare Expiry:		☐ DVA	Number:
Pension Number:		☐ DVA Gold Card	Number:
Pension Type:		☐ Workcover	Number:

GP DETAILS:

Name:		Phone:	
Address:			

REFERRER DETAILS:

Referrer Name:		Designation:	
Hospital/Service Name:		Contact Number:	
Email Address:		Referral Date:	

COMMUNITY REFERRAL FORM (Page 2 of 2)