

MONASH HEALTH

POST ACUTE CARE REFERRAL

Community Access Email Address:

icareaccess@monashhealth.org

Phone: 8572 5631

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 applicable): |
|--------------------------------|-------------------------------------------|

| | |
|-------------------------------------------------------|--------|
| 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 |
| Risk management plan discussed with client and PAC | | | | COVID Positive Clearance Date |
| If Level 3-4 package, have you liaised with Case Manager & reason why package cannot fund PAC service? | | | | Other (eg. VRE) |

| 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 |

POST ACUTE CARE REFERRAL

MONASH HEALTH**POST ACUTE CARE REFERRAL**Community Access Email Address:
icareaccess@monashhealth.org

Phone: 8572 5631

UR:

Patient Name:

DOB:

Sex:

Address:

Mobile:

Email:

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: