My Aged Care Community Health Professional and GP Fax Referral Form

Important:

* Complete all relevant sections. Fax only one patient/client referral at a time and please only send one referral per client/patient.
* Use this form for referring to My Aged Care for access to Commonwealth Home Support Services, Home Care Packages, Residential Care or Residential Respite.
* Please consider using the online form for faster and more efficient outcomes for your patients/clients. Confirmation of receipt will also be provided when using the online form.

Fax completed form to My Aged Care: 1800 728 174

Note. This referral does not guarantee access to services. Provision of service will be dependent on service availability in the area and the client’s specific needs.

| Referrer Details\*(\*denotes a section that must be completed) | | | |
| --- | --- | --- | --- |
| Name of Referrer: | Click in shaded areas only | Referrer Ph: |  |
| Organisation Name: |  | Referrer Role: |  |
| Org. Address: |  | | |

| Patient/Client Details\* | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: |  | | | Last Name: | |  | | | | |
| Gender: |  | | | DOB (dd/mm/yyyy): | | dd / mm / yyyy | | | | |
| Home address: |  | | | | | | | | | |
| Can the patient be contacted by phone? | Yes  No | | | Patient Ph: | |  | | | | |
| Medicare Card#: (including IRN) |  | | | DVA Card #: | |  | | | | |
|  | | | DVA Card Colour: | | Gold | | White | | Orange |
| Is your patient of Aboriginal or Torres Strait Islander origin? | | Aboriginal | Torres Strait Islander | | Both | | Neither | | Unknown | |
| Interpreter Required: | Yes  No | | | Specify Language: | |  | | | | |

CONFIDENTIALITY NOTICE: This facsimile transmission may contain confidential information, which is legally protected. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in this transmission is strictly PROHIBITED. Recording, disclosing or otherwise using the information could be an offence under the Aged Care Act 1997. If you have received this transmission in error, please immediately notify us by phone on 1800 200 422. THANK YOU.

| Consent For Referral\* This section must be completed for the referral to be actioned *Consent to make this referral also includes consent from the patient /client to have their personal information stored within My Aged Care, and for it to be provided to relevant assessment organisations, service providers and health professionals, and consent to share information back with you (the referrer) about the referral.* | | | | |
| --- | --- | --- | --- | --- |
| Has consent been provided for this referral? | | Yes  No | | |
|  | | | | |
| If not patient, consent provided by: |  | | Ph: |  |
| Relationship to the Patient: |  | | | |
| Reason if not the Patient: |  | | | |

| Additional Patient/Client Information | | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Does the patient have a carer/support person? | | | | | | Yes  No | | | | | | | | | | | |
| Usual Living Arrangements: | | Alone  With Family/Partner/Carer  Homeless Other: | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Details of Carer/Support person 1: | Relationship to the Patient: | | Partner | Child | | | Parent | | Neighbour/Friend | | | | | | | | Other: |
| Name: | |  | | | | | | | | Ph: | | |  | | | |
| Address: | |  | | | | | | | | | | | | | | |
| Do they need to be present at any aged care assessments? | | | | | | | | | | | Yes  No | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Details of Carer/Support person 2: | Relationship to the Patient: | | Partner | | Child | | | Parent | | Neighbour/Friend | | | | | | | Other: |
| Name: | |  | | | | | | | | | Ph: | | |  | | |
| Address: | |  | | | | | | | | | | | | | | |
| Do they need to be present at any aged care assessments? | | | | | | | | | | | Yes  No | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| GP Details: | Name: | |  | | | | | | | | | | Ph: | | |  | |
| Practice name: | |  | | | | | | | | | | | | | | |

| Why The Patient/Client Is Seeking Services Or Requires An Assessment\* |
| --- |
| Description of problem or issue as identified by the referrer or patient, for example relevant medical conditions, reason for admission, mobility, fall risk or cognition issues. |
| Click to add text |

| Patient/Client Concerns\* | | Are there concerns with any of the following? Please select all that apply | | |
| --- | --- | --- | --- | --- |
|  | Health concerns impacting independence | |  | **Feeling lonely, down or socially isolated** |
|  | Recent falls | |  | **Memory loss or confusion** |
|  | Pain | |  | **Risks, hazards or safety concerns in their home** |
|  | Weight loss or nutritional concerns | |  | **Special needs** |

| Patient/Client Function\* | | Based on your knowledge is the patient/client able to: | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Without help | | **With a little help** | | **With a lot of help** | | **Completely unable** | | **Not known** |
| Get out of bed or chairs easily? |  | |  | |  | |  | |  |
|  | Without help | | | **With some help** | | **Completely unable** | | **Not known** | |
| Eat their meals? |  | | |  | |  | |  | |
| Go to the toilet? |  | | |  | |  | |  | |
| Walk easily? |  | | |  | |  | |  | |
| Shower or have a bath? |  | | |  | |  | |  | |
| Manage their own medications? |  | | |  | |  | |  | |
| Travel in the community? |  | | |  | |  | |  | |
| Go shopping for groceries? |  | | |  | |  | |  | |
| Prepare their own meals? |  | | |  | |  | |  | |
| Do housework? |  | | |  | |  | |  | |
| Manage their money? |  | | |  | |  | |  | |
|  | | | | | | | | | |
| **Patient/Client Function: How can you use this information?**  If you have answered “without help” for most activities and “some/a little help” for a few activities, the patient may benefit from access to one or more Commonwealth Home Support Program (CHSP) services. Access to these services would be determined by an assessment undertaken by a Regional Assessment Service (RAS).  If you have answered “with a lot of help” or “completely unable” for a number of activities, the patient may benefit from more extensive support such as a Home Care Package or may benefit from Residential/Respite Care or Transition Care. Access to these programs would be determined by an assessment undertaken by an Aged Care Assessment Team (ACAT). | | | | | | | | | |

| Recommendation\* | | I want to recommend my patient/client for: | | |
| --- | --- | --- | --- | --- |
|  | **Comprehensive assessment by an Aged Care Assessment Team (ACAT)** | | Complete section A | *Recommended if your patient has a low level of function and would benefit from access to a Home Care Package or Residential Care* |
|  | **Home support assessment by the Regional Assessment Service (RAS)** | | Complete section B | *Recommended if your patient has a high level of function and would benefit from access to CHSP services* |

| Section A: Recommended for ACAT Assessment | | | |
| --- | --- | --- | --- |
| To support aged care assessment, please specify the aged care programs your patient would benefit from: | | | |
| Residential Care | | Residential Respite | Home Care Package |
| Location of Assessment | Usual residence | | |
| Other (please specify): | | |

| Section B: Recommended for RAS Assessment (CHSP Services) | | | |
| --- | --- | --- | --- |
| To support aged care assessment, please specify the types of services the patient would benefit from: | | | |
| Community Nursing | Transport | | Meals |
| Personal Care | Domestic Assistance | | Home Modifications |
| Allied Health, please specify: |  | | |
| Other, please specify: |  | | |
| Estimated duration of services: | Short term (< 6 weeks)  Medium term (6 – 12 weeks)  Long term (> 12 weeks) | | |
| Date Services Required: | |  | |

| Additional Information | |
| --- | --- |
| Have you attached relevant case information including allied health assessments, wound care details, discharge summaries, care plans or relevant medical summaries? (please do not fax the patient/client file) | Yes  No |
| Other comments: | |