**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 \****

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| **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**