|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **This form is to be completed by the Care Manager making the referral** | | | | | | | | |
| **Referrer’s Name:** | | | | | | **Location:** | | **Referral Date:** |
| **Referrer’s email:** | | | | | | | | **Mobile:** |
| **Urgent** | **Yes *(specify why)*** | | | | | | | **No** |
| **Is there a previous nursing assessment** | | | | **Yes** | | **No** | | |
| **Is there a current Consent form** | | | | **Yes** | | **No**  **(If no please obtain)** | | |
| **Referral Reason** | | | | | | | | |
| **HCP Clients Package Level** | | | **Level 1**  **Level 2**  **Level 3**  **Level 4**  **N/A** | | | | | |
| **Nursing Health Assessment** | | | **Initial** | | | **Date client was accepted onto the HCP:** | | |
|  | | | **Review** | | | | | |
| **Package Supplements to be assessed** | | | **None**  **Dementia and Cognition Supplement** | | | | | |
| **Wound Care *(Please specify wound location)*** | | |  | | | | | |
| **Other services *(Please specify*)** | | |  | | | | | |
| **NDIS** | | | **Clients NDIS Number:** | | | | | |
| **Services included in Budget** | | | **Diabetic supports**  **Continence Supports**  **Wound/Pressure Care**  **Other (Please Specify)** | | | | | |
| **Client Details** | | | | | | | | |
| **Name:** | | | | | | | **DOB:** | |
| **Home Address:** | |  | | | | | | |
| **Contact person to schedule the appointment:** | | **Contact Name:** | | | | | **Relationship to client:** | |
| **Contact Phone Number:** | | | | | | |
| **Is an Interpreter required** | | **Yes *(Please specify*)** | | | | | **No** | |
| **Other Comments:** *(i.e. health concerns, hospital discharge, dress code in the client’s home, diversity, allergies, medical considerations)* | | | | |  | | | |
| **Any additional OHS risk/concerns in the home:** | | | | | **The entry to the home is** | | | |

**Return to: nursing@communitygateway.net.au**