



REFERRER DETAILS			Date of Referral	
Referrer Name			Last Name	
Position			Organisation	
Address				
Phone No.			Email	
Fax No.			HealthLink EDI	
PATIENT DETAILS				
First Name			Date of Birth	
Last Name			Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other / Unstated
Address				
Home Phone			Email	
Mobile Phone			Consent to referral	<input type="checkbox"/> YES <input type="checkbox"/> NO
ELIGIBILITY CRITERIA FOR PATIENT BEING DISCHARGED FROM HOSPITAL / REFERRAL REASON				
1) <input type="checkbox"/> Yes, living with three or more chronic health conditions/comorbidities. 2) <input type="checkbox"/> Yes, at risk of readmission to hospital after transitioning home. 3) <input type="checkbox"/> Yes, would benefit from short term follow-up support. 4) <input type="checkbox"/> No, the patient does receive any package which already provides a comprehensive support service component (e.g., COMPAC, TRANSPAC, CHSP, HCP, NDIS, etc.)				
Key Issues Identified (e.g., no current supports at home, no community care supports in place, multiple follow-up appointments need to be organised, home environment may need review, new medications need to be filled, assistive equipment required, etc.)				
ADDITIONAL CLIENT INFORMATION				
Country of birth			Main language spoken at home?	
Aboriginal	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>(If needed - tick both)</i>	Communication support required? (Please provide details)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Torres Strait Islander	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Employment status	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Benefits, please specify:			
Are there any risk factors we should be aware of when visiting the home/client?	<input type="checkbox"/> NO <input type="checkbox"/> YES - please specify or attach existing risk assessment if available.			
ADMISSION INFORMATION				
Hospital Name			Hospital Ward	
Ward Phone			Ward Fax	
Reason for Admission				



DISCHARGING DOCTOR / TREATING SPECIALIST

Doctor's Title	Doctor's Phone
First Name	Doctor's Fax
Last Name	Doctor's Email
Specialty	HealthLink EDI

GP DETAILS

GP Name	Last Name
GP Practice	Provider #
Address	
Suburb	Post Code
Phone No.	Email
Fax No.	HealthLink EDI

DISCHARGE PLANNING & POST DISCHARGE INFORMATION

Planned Discharge Date	Planned Discharge Time
Upon discharge will the client be able to manage independently for the next 48 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No If NO , provide details:
Does the client require any medication post-discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES , provide details:
Does the client require any equipment post-discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES , provide details:
Does the client require any review by a health professional or additional imaging/pathology?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES , provide details:
Are there concerns that the clients is not capable of making their own decisions?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES , describe:
Are Guardianship/ Enduring powers of attorney in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES , provide details:
Does the client have any supports to help at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES , provide details:

ASSOCIATED DOCUMENTS

- 1) Yes, I have attached the Patient's Health Summary (if available)
- 2) Yes, I have attached the Patient's Discharge Summary (if available)
- 3) Yes, I have attached the Patient's Care Plan (if available)

RETURN REFERRAL TO: HealthLink EDI: gpsocial Fax: 1300 067 747 Or Call Us On (02) 9477 8700

OFFICE USE ONLY Date: Accepted Referral not accepted, reason: