FORM ON TRIAL
1 NOV 2013 - 1 MAR 2014
(To be filed in Medical Record)

Community Health
ST VINCENT'S HOSPITAL
SYDNEY

FlexICare Referral Form

MRN		SURNAME	
GIVEN NAME(S)			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

Please complete Form with as much information as possible.
If you would like assistance, please call the O'Brien Referral Centre staff on 8382 1450.
Fax Form to 8382 1997 or email to orc@stvincents.com.au

Referred by _____ Phone _____ Mob _____ Fax _____

Organisation _____ Position / Relationship to Client _____ Date of Referral ___/___/___

Ward _____ Hospital _____ AMO _____

Admission date ___/___/___ Discharge date ___/___/___

Client surname _____ Given names _____

Gender ☐ Male ☐ Female ☐ Other / unknown DOB ___/___/___ MRN _____

Discharge Address *(if different to Bradma)* _____

Suburb _____ Postcode _____

Phone: Home _____ Mobile _____ Work _____

Email _____ Preferred method of contact _____

Language _____ Interpreter required Y / N

Communication issues *(eg. sensory impairment, literacy difficulties)* _____

☐ Aboriginal ☐ Torres Strait Islander

Contact person or next of kin Name _____ Relationship to Client _____

Address _____ Suburb _____

Phone: Home _____ Mobile _____ Work _____

GP _____ Phone _____ Suburb _____

Is GP aware of referral Y / N Is Client aware of referral Y / N Date patient last visited GP ___/___/___

Financial details: DVA Gold Card Y / N Number _____

Medicare No. _____ Expiry ___/___ Pension Y / N Number _____

BINDING MARGIN - NO WRITING
St Vincent's Hospital Sydney Limited
ABN 77 054 038 872

FLEXICARE REFERRAL FORM

ST VINCENT'S HOSPITAL
SYDNEY

FlexICare Referral Form

MRN		SURNAME	
GIVEN NAME(S)			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

Medical History

Known Allergies

Reason for Referral

THIS SECTION MUST BE COMPLETED

Service Required *(please tick)*

- ☐ Nursing
- ☐ Social Work
- ☐ Diabetes Centre
- ☐ Heart Failure
- ☐ Dementia
- ☐ Physiotherapy
- ☐ Hospital in the Home
- ☐ Community
- ☐ Hospital in the Clinic*
- ☐ Other: _____
- ☐ Occupational Therapy
- ☐ Therapy in the Home
- ☐ Podiatry
- ☐ Complex Foot Service
- ☐ Community Podiatry Service

For Hospital in the Clinic:
Is referral for an admitted treatment? (Anything other than Wound Care, IV antibiotics, IV Methylpred, IM Medications or IV Cernavit) Yes / No

WorkCover treatment *Yes / No* | ***Medicare treatment*** *Yes / No* | ***URGENT*** *(less than 40 hours) Yes / No*

For internal use only ☐ H/O Falls ☐ Carer burden ☐ Increased frailty

Communication Impairment
Speech Yes No
Hearing Yes No
Vision Yes No
Aids: .....
.....

Cognition
Oriented Yes No
Confusion Yes No
☐ New ☐ Old
☐ Deterioration
Dementia Diagnosis Yes No

Mobility
☐ Independent
☐ Independent with aid
☐ Assist x 1 / x 2
☐ Wheelchair
☐ Bed bound

Personal Risk Assessment
☐ Verbally threatening
☐ Acts of aggression
☐ Sexual harassment
☐ Other .....
.....

Social
Lives alone Yes No
Carer Yes No
Carer lives w/client Yes No
Is carer available? Yes No
Relationship .....
.....

Accommodation
☐ Home owner
☐ Rental: ☐ Private ☐ Public
☐ Boarding House
☐ Unknown
☐ Other .....
.....

Palliative Care Yes No
Endstage Yes No
Diagnosis Yes No

Continent
☐ Urine ☐ Faeces
Self caring Yes No

St Vincent's Hospital

Community Health Service
Level 3 the O'Brien Centre
390 Victoria Street
Darlinghurst NSW 2010

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Medical Authority to Change an Indwelling Catheter

Name :..... **DOB** :.....

Urological Reason for Catheter: .....

☐ Long Term ☐ Short Term

Urologist: .....

Catheter Site: ☐ Urethral ☐ SPC

Catheter Type: .....

Catheter Size: .....

Change: ☐ Every 4 Weeks ☐ Every 6 Weeks

☐ Other: Every ..... Weeks

Last Change: .....

Spinal Cord Injury? ☐ YES ☐ NO

If yes, history of Autonomic Dysreflexia? ☐ YES ☐ NO

If a client with spinal cord injuries has a history of autonomic dysreflexia during catheterisation, their catheter will NOT be changed in the community setting. The catheter will need to be replaced in a hospital where emergency medical treatment is available.

Name (print): ..... Position: .....

Signature: .....

Contact Number: .....

Date: ..... / ..... / .....

- Please advise if you have any difficulty with this –