ST VINCENT'S HOSPITAL
SYDNEY

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

(Please enter information or affix Patient Information Label)

FlexICare Referral Form

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 **svhs.orc@svha.org.au**

Referrer Details:

Referred by: ____________________ Phone: ______________ Mob: ______________ Fax: ______________

Organisation: ______________ Position/Relationship to Client: ______________ Date of Referral ____/____/____

Address/Ward and Hospital: ____

____

Client Details:

Address (*if different to Patient Information Label):* ____

Suburb: ________________________________ Postcode: ______________

Phone: Home ______________ Mobile ______________ Work ______________

Email: ______________ Preferred method of contact: ______________

Language: ______________ Interpreter required: Y / N

Communication issues *(e.g. sensory impairment, literacy difficulties)* ______________

☐ Aboriginal ☐ Torres Strait Islander Is client aware of referral: Y / N

Nominated person for contact: ______________ Relationship to client: ______________

Address: ________________________________ Suburb: ______________

Phone: Home ______________ Mobile ______________ Work ______________

GP: ______________ Phone: ______________ Suburb: ______________

Is GP 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: ______________

Work Health Safety Risk Assessment:

Are there any safety issues *(e.g. access to home, behavourial issues, pets, smoking)?* ☐ Yes ☐ No

If Yes, please list: ____

Has the patient received antineoplastic (cytotoxic) medication within the last 7 days? ☐ Yes ☐ No

What is the patient's Resuscitation Status? *(Please attach to Referral)* ______________

Are there Advanced Care Directives in place? *(If yes, please attach to Referral)* ☐ Yes ☐ No

Comments: ____

____

____

FLEXICARE REFERRAL FORM

BINDING MARGIN - NO WRITING

St Vincent's Hospital Sydney Limited
ABN 77 054 038 872

Updated October 2017

SV013*****

G:SVH:FORMS:2013.FlexiCare

ST VINCENT'S HOSPITAL
SYDNEY

MRN	SURNAME
GIVEN NAME(S)	

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(Please enter information or affix Patient Information Label)

FlexICare Referral Form

Medical History
Known Allergies
Reason for Referral

THIS SECTION MUST BE COMPLETED

Service Required *(please tick)*

☐ **Community Nursing**	☐ **Physiotherapy**	☐ **Occupational Therapy**
☐ **Social Work**	☐ **Hospital in the Clinic**	☐ **High Risk Foot Service**
☐ **Diabetes Centre**	☐ **Chronic Care Coordination**	☐ **Community Podiatry Service**
☐ **Heart Failure**	☐ **COPD Outreach**	☐ **Dementia**

Hospital in The Home Referrals please see HITH Referral Form.

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

For internal use only	☐ History of 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 agression ☐ 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

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