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| --- | --- | --- | --- | --- | --- | --- |
| DOB |  | | | | PID Number | |
| Gender |  | | | |  | |
| Title |  | | | Surname |  | |
| Given Names | | |  | | | |
| Address | |  | | | | |
|  | | | | | | *(Type or affix sticker)* |

**Referral phone line 1300 300 122 is available for enquiries 24/7**

Please provide all relevant referral information for eligibility screening. A Silverchain nurse will call if further information or clarification is required.

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| --- | --- |
| REFERRER DETAILS | |
| Hospital: | Ward: |
| Referrer name: | Referrer phone: |
| Referrer role: | Referrer email: |
| Treating doctor’s name: | Contact number: |
| Treating doctor’s speciality: | Signature: |
| *The treating doctor declares the client is medically suitable for discharge and not discharging against medical advice.* | |
| Doctor Responsible for Medical Governance (if applicable):  Contact Number (24/7): | |

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| --- | --- | --- |
| **CLIENT DETAILS** | | |
| Given name(s): | Surname: | |
| Address: | | |
| Telephone: | | Date of Birth: |
| Email: | | |
| Medicare Number:       Ref: | | URN: |
| Next of Kin (NOK)/Carer Name: | | NOK Phone: |
| Usual GP: | | GP Phone: |

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| **REFERRAL DETAILS** | | | | | |
| **Presenting Complaint/Diagnosis:** | | | | | |
|  | | | | | |
| **Hospital admission dates:** | | | | | |
| Admission date: | [Choose date] | Surgery date:  (if applicable) | [Choose date] | Discharge date: | [Choose date] |
| **Surgery details (if applicable)** (including any complications during admission and infection status)**:** | | | | | |
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| **Treatment requested** (care type, expected duration and follow-up required): | | | | | | |
| **IV Therapy**  IV antibiotics  IV iron infusion  IV hydration (hyperemesis <20 weeks)  Other IV infusion  **Other non-IV medication** | | **Anti-coagulation Therapy**  LMWH (Clexane/other)  NOAC  Warfarin | | **Wound and Drain care**  Wound care  Drain Tube care  NPWT  PICC/PORT/VAD care  Newly commenced insulin therapy  Newly commenced stoma care | | **Catheter care**  TOV (from ED)  TOV (Inpatient)  IDC/SPC support |
| Details of treatment requested: (For NPWT, please provide device details, wound type, size, and location) | | | | | | |
| Start 1st visit date: | [Choose date] | | First visit timeframe: | | AM  PM | |
| **Relevant medical, surgical and social history** | | | | | | |
|  | | | | | | |
| **Allergies, impairment or risk factor details: (e.g. falls, vision, hearing, cognitive)** | | | | | | |
|  | | | | | | |
| Is the patient pregnant?  No  Yes gestation:       weeks (> 20 weeks will require discussion with Silverchain CNM, for acceptance) | | | | | | |
| **To be considered for the safety of visiting staff:** | | | | | | |
| Yes  No History of aggression or violence  Yes  No History of inappropriate behaviour  Yes  No History of substance abuse  Yes  No Any other risks for home visiting (behavioural/social issues, domestic violence, infectious diseases)  Details: | | | | | | |
| Is the patient receiving any other community care services?  No  Yes (if yes, include HCP level)  Details: | | | | | | |

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| **TREATMENT REQUEST DETAILS** (complete relevant section only) | | |
| **FOR ALL REFERRALS:** | | |
| **Attached latest pathology and/or radiology results as per** [**Silverchain Clinical Protocols**](https://silverchain.org.au/refer-to-us/clinical-protocols) | | |
| **FOR CLIENTS REQUIRING IV THERAPY:** | | |
| General  Silverchain Home Hospital Medication Order form is attached  IV route and device specified.  Route:       Device:  Is IVC difficult to site?  Yes  No  First dose has been administered without contra-indication  For IV Antibiotics  Yes  No If IV Antibiotics are required for >2 weeks, has an Infectious Disease Consultant reviewed the client?  If No, client must have a review before discharged and ID follow-up arranged, and details provided  Yes  No Will you supply consumables/medications for the first visit if patient is discharged on a Friday >12pm, over a weekend or on a public holiday? (Silverchain can only order medications on business days)  *Note: the cut-off time for ordering medication consumables (as above) is 12.00pm for next day delivery.*  For IV Iron Infusions  Yes  No Client must be able to attend a Silverchain Clinic.  Yes  No Is the client symptomatic? If Yes, provide details in relevant medical history section  For IV Hydration  Yes  No Confirmed diagnosis of hyperemesis.  Yes  No Have oral antiemetics been used first? | | |
| **FOR CLIENTS REQUIRING ANTI-COAGULATION THERAPY (including pre- and post- surgical bridging):** | | |
| General  Silverchain Home Hospital Medication Order form attached  Indication/reason for anti-coagulation documented in relevant medical history  For DVT/PE  Details of DVT/PE. Size:       Location:  For pre- and post- procedure / surgical intervention bridging  Yes  No Will post-surgical bridging be required?  Yes  No Is the procedure a Day procedure? If no, a new referral will be required prior to discharge.  Date of procedure: [Choose date]  Details of procedure:  Anti-coagulation type to be administered: | | |
| LMWH (Clexane/other) | Warfarin | NOAC |
| Therapeutic  Bridging  Commencement date:  [Choose date]  If to cease, date: [Choose date]  Current weight:      kg | Target INR:  Latest INR:  Commencement date:  [Choose date]  Usual dose:      mg  Script for discharge attached | Type:  Cease date: [Choose date]  Commencement date:  [Choose date] |
| **FOR CLIENTS REQUIRING WOUND, DRAIN, NEW INSULIN OR STOMA CARE:** | | |
| General  Wound management plan attached.  Silverchain Home Hospital Medication Order form attached.  Choose care to be provided | | |
| PICC/PORT/VAD care | Newly commenced insulin treatment | Newly commenced stoma care |
| Device type:  Date inserted: [Choose date]  Device safe to use report is attached.  PICC insertion details in wound management plan. | Blood sugar levels stable for three consecutive days.  Patient has own glucometer machine.  Diabetic parameters details provided for escalation. | Stoma consumables organised.  Stoma Support Plan is attached |
| **FOR CLIENTS REQUIRING CATHETER CARE:** | | |
| General  Reason for insertion including urological history provided in relevant medical history section.  For TOV  Yes  No Is the client under the care of a Urologist for referral should the TOV fail?  Urologist name and contact:  Yes  No Is there hydronephrosis or abnormal renal function at the time of retention?  Yes  No Has there been recent bladder, urethral or prostate surgery?  Provide bladder stretch details (if known) below.  Details: | | |