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

**FAX to 1300 601 788**

**Please check ALL fields are completed.**

**Date:** select date

**Referrer Details:**

|  |  |
| --- | --- |
| [ ]  Medical Practitioner Name (Please print clearly) |       |
| Is this medical practitioner accepting clinical governance? | [ ]  Yes [ ]  No |

Name of Medical governance:

|  |
| --- |
| **Name of Organisation/Facility:**       |
| **Provider Number:**       |
| **Referrer/Facility Street Address:**       |
| **Suburb:**       | **Postcode:**       |
| **Telephone:**       | **Fax:**       |
| **Email:**       |
| **Referrer/Facility** **Contact Person:**       |
| **Signature:**       |

**Client Details** (Please print clearly)

|  |  |
| --- | --- |
| First Name:       | Surname:       |
| Unit No:       | Street No:       | Street Name:       |
| Suburb:        | Postcode:       |
| Date of Birth:       | PID [if known]:       |
| Telephone:       | [ ]  Male | [ ]  Female |
| Living Arrangements: [ ]  Lives alone [ ]  With family [ ]  With others [ ]  Not stated |
| Name of Carer [if applicable]:       | Telephone:       |
| Name of Next of Kin | Telephone:       |
| Country of Birth:       | Preferred Language:       |
| [ ]  Pensioner **or** [ ]  Health Care Card number:       | Exp date:       |
| Please Note: Commonwealth Seniors Health Care card is not accepted for this service |
| Is the client Aboriginal or/and Torres Strait Islander? | [ ]  Yes [ ]  No |
| Is client permanent resident of WA = six months or more? | [ ]  Yes [ ]  No |
| Has client had chronic incontinence for = six months or more? | [ ]  Yes [ ]  No |
| Is the client receiving an NDIS package?If yes client is eligible for assessment only | [ ]  Yes [ ]  No |
| Is client receiving a Home Care Package level 1 - 2?If yes client is eligible for assessment only | [ ]  Yes [ ]  No |
| Is client receiving a Home Care Package level 3 - 4?If answer is Yes, client ineligible for service. | [ ]  Yes [ ]  No |
| Does the client reside in a residential aged care facility?If answer is Yes, client ineligible for service. | [ ]  Yes [ ]  No |
| Has the client been seen by an external Continence Service other than Silverchain in the last 12 months? | [ ]  Yes [ ]  No |
| Does client have dementia or other cognitive impairment? | [ ]  Yes [ ]  No |
| Is there any concerns with client communicating via telephone? | [ ]  Yes [ ]  No |
| Is the named Next of Kin or Carer best to communicate on client’s behalf? | [ ]  Yes [ ]  No |
| Name and contact details for Next of Kin/Carer |       |
| Reason for Referral:        |
| **If this client requires catheter care then a referral to community nursing needs to be made separately. www.silverchain.org.au/refer-to-us/western-australia/community-nursing** |
| Please attach current Medical Summary including medical and surgical history.Please attach any relevant Urology/Urogynaecology or Gynaecaology communications.  |
| Please attach current medication list including allergies. |

**CMAS Eligibility Criteria**

* Permanent resident of Western Australia
* Clients who have experienced long term bladder and or bowel problems.
* Hold a pensioner concession card or health care card.
* Not in receipt of a Commonwealth Home Support Program - Home Care Package level 3 or level 4
* Clients in receipt of a home care package level 1 and 2 are eligible for assessment only.
* Clients in receipt of a National Disability Insurance Scheme (NDIS) Package are eligible for assessment only.
* Clients in receipt of a National Disability Insurance Scheme (NDIS) have their continence supplies funded through this package.

Fax referral to 1300 601 788 or email SCReferrals@silverchain.org.au.

**Following Receipt of Referral**

Silverchain will contact the client directly to arrange an assessment. This may be either via phone/SMS/letter.

For enquiries call the Continence Management and Advice Service (CMAS) on 1300 650 803 and ask for the Clinical Nurse Manager.