

FOR MEDICAL RECORD USE ONLY	SURNAME: _____ MRN: _____ OTHER NAMES: _____ DOB: _____ SEX: _____ AMO: _____ AFFIX PATIENT ID LABEL HERE
-MEDICAL RECORD COPY -	
South Eastern Sydney Illawarra Area Health Service	
Access and Referral Intake Form	

Referred by (Name) _____ Contact No. _____ Designation/ Relationship _____
 Ward _____ Hospital _____ Discharge Date _____ Date of Referral _____
 Proposed Commencement Date for Community Nursing _____ Medical/ Nursing Discharge Summary Attached

Patient Details: Surname _____ Given Names _____
 DOB ___ / ___ / ___ Male Female Marital Status: Married/ De facto/ Never Married/ Separated/ Divorced/ Widowed/ Unknown
 Temporary/ Discharge Address _____ Suburb _____ Postcode _____
 Home Number _____ Work Number _____ Mobile Number _____
 Permanent Address _____ Suburb _____ Postcode _____
 Phone Number _____ Aboriginal? Yes No Torres Strait Islander? Yes No
 Country of Birth _____ Preferred Language _____ Interpreter Required? Yes No

GP Name: _____ Phone Number _____ Fax Number _____
 Address _____ Suburb _____ Postcode _____
 Is the GP aware of this referral? Yes No Is the Patient/ Carer aware of this referral? Yes No

Contact Person: Name _____ Relationship to Patient _____
 Address _____ Suburb _____ Postcode _____
 Phone Numbers: Home _____ Work _____ Mobile _____
2nd Contact Person: Name _____ Relationship to Patient _____
 Phone Numbers: Home _____ Work _____ Mobile _____

Financial Details: Pension Type: Aged Disability Support Carer Overseas Self Funded
 Medicare Number: _____ DVA No. _____ Card Colour: Gold White

Diagnosis/ Medical History: (include any other relevant details – co morbidities, allergies, test results)

Service Requested/ Patient's Needs: (description of problem or issue – e.g ADL management and treatment being received)

Multi-Resistant Organism and/or Infection Alert: No Yes Type/site.....Biohazard Alert:

Other Referrals Made: (Include services and contact details)

Other Community Services Already Received: (Include services and contact details)

Communication Impairment: Speech: Yes <input type="checkbox"/> No <input type="checkbox"/> Hearing: Yes <input type="checkbox"/> No <input type="checkbox"/> Vision: Yes <input type="checkbox"/> No <input type="checkbox"/> Aids: _____	Cognition Orientated Yes <input type="checkbox"/> No <input type="checkbox"/> Confused New <input type="checkbox"/> Old <input type="checkbox"/> Deterioration <input type="checkbox"/> Dementia Diagnosis Yes <input type="checkbox"/> No <input type="checkbox"/>	Mobility <input type="checkbox"/> Independent <input type="checkbox"/> Independent with aid <input type="checkbox"/> Assist x 1 <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bed bound	Personal Risk Assessment: Verbally threatening: Yes <input type="checkbox"/> No <input type="checkbox"/> Acts of aggression: Yes <input type="checkbox"/> No <input type="checkbox"/> Sexual harassment: Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____
Social: Lives Alone: Yes <input type="checkbox"/> No <input type="checkbox"/> Carer: Yes <input type="checkbox"/> No <input type="checkbox"/> In hospital or Away <input type="checkbox"/> Relationship: _____	Palliative Diagnosis: Yes <input type="checkbox"/> No <input type="checkbox"/> End Stage Yes <input type="checkbox"/> No <input type="checkbox"/> Diagnosis: _____	Continence: Yes <input type="checkbox"/> No <input type="checkbox"/> IDC <input type="checkbox"/> SPC <input type="checkbox"/> Self Caring Yes <input type="checkbox"/> No <input type="checkbox"/>	

Ambulatory Care Unit: AMO Signature: _____ Name: _____ Date: _____

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Service: _____	Case Manager: _____	Start date/ Urgency: _____

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**South Eastern Sydney Illawarra Area Health
Service****Access and Referral Intake Form**

SURNAME: MRN:

OTHER NAMES:

DOB:

SEX:

AMO:

AFFIX PATIENT LABEL HERE

FALLS:Have you had any falls in the past 6 months? Yes No If yes, how many? _____Did you need medical help post fall? Yes No If yes, by whom? _____Do you have any problems with balance or walking? Yes No If discharged from hospital - Falls Risk Screen score _____ N/A **MEDICATION:**Do you take medication every day? Yes No If yes, how many? _____Do you understand what they are for? Yes No Have you had your medications changed recently? Yes No If yes, do you understand why? Yes No **Usual administration of medication:** Self with a written list Self without a written list Carer or partner Webster pack, dosette**COGNITION:****Patient Contact**Do you have any concerns regarding your memory? Yes No

▪ If yes, please state: _____

Other Contact

Does the person have memory problems or become confused? E.g. Do they ask the same questions repetitively?

Yes No Has the person had changes to their behaviour or personality in recent months? Yes No **OBSERVATIONAL CHECKS (only for face to face contact)**Does the patient appear well nourished? Yes No Does the patient look disheveled? Yes No Does the patient appear agitated or confused? Yes No **ACTIONS:-** Forward screen to GP
hospital Note identified risks Note follow up response from**CARER ASSESSMENT****Sustainability of care arrangements: (Tick all the current threats that apply)**Carer emotional distress Carer - acute physical exhaustion Carer – slow physical health deterioration Carer – factors unrelated to care situation Patient – increasing needs Patient – other factors **Are arrangements sustainable without additional support services?** Yes No