Referral to Bolton Clarke

At Home Support

Referrer: Please complete this form and fax it to Bolton Clarke as follows:
Melbourne: 1300 657 265; **Other Vic** (03) 5225 5799; **NSW** (02) 6584 5940; **QLD & Nth NSW:** 1300 792 129; **SA & WA:** 1300 768 296

This form is available from the 'Referrers' area in boltonclarke.com.au/referrals/ **Phone:** 1300 22 11 22

Client details:

(Attach adhesive label if appropriate)

Name: (Given name) (Family name)	**Bolton Clarke UR:** (if known)
Address:	
	Phone:
Date of birth:	**Gender:**
Next of kin/contact:	**Phone:**
Interpreter required: ☐ No ☐ Yes **Language spoken at home:**	
Diagnoses:	
Relevant past history:	
Allergies:	
Pension/DVA number: (if applicable)	
Client is aware of referral ☐ Yes ☐ No	
GP details if not referrer **Name:** _____ **Address:** _____ _____	**Phone:** _____ **Fax:** _____

Referrer details:

(Complete as applicable)

Organisation/network: (e.g. Peninsula Health)	**The information has been faxed/phoned** ☐ Yes ☐ No
Hospital/facility:	**Ward/clinic:**
Referrer name:	**Phone:**
Email:	**Fax:**
Planned discharge date:	**Requested first visit date:**
GP/hospital DVA provider no.: (NOT client's VX number)	**ABN:**
Days you usually visit the client (Community referrers)**:**	

Referral to Bolton Clarke

Name: **UR:**

At Home Support (continued)

Nursing care requested: (see below for home assistance)

(Tick as many as required)

- ☐ Nursing assessment
- ☐ Continence management
- ☐ Urinary catheter management ⚠
- ☐ General nursing management
- ☐ Stomal therapy
- ☐ Personal care
- ☐ Aged care
- ☐ Technical care ⚠
- ☐ IV therapy ⚠
- ☐ Bowel management ⚠
- ☐ Medication management ⚠
- ☐ Pain management
- ☐ HIV/AIDS management
- ☐ Diabetes management ⚠
- ☐ Palliative nursing care
- ☐ Wound management
- ☐ Other: (specify) _____

Additional information:

⚠
- Please include information about **infections** (e.g. MRSA / VRE) and a **medication summary**.
- If you have requested an **invasive procedure** or **medication administration** (e.g. IV therapy, catheter management, wound care), please include or attach **medical authorisation** with details (e.g. medicine details, type and size catheter, specific wound regime).

☐ Required equipment has been provided ☐ I have included/attached medical authorisation

Home assistance:

(Tick as many as required)

- ☐ Domestic assistance
- ☐ Shopping
- ☐ Transport
- ☐ Personal care
- ☐ Social support
- ☐ Other: (specify)
- ☐ Respite

Relevant information:

⚠ Please advise if there is any actual or potential risk to Bolton Clarke staff security.

On chemotherapy: ☐ No ☐ Yes – **details:**

Cognitive status:

Continence:

Mobility: (Bolton Clarke staff will not be able to use the hoist unless it was serviced in the past 12 months.)

Hoist to be used by BC: ☐ No ☐ Yes **If yes, date of last service:**

Client safety issues:

Carer:

At risk:

Access to home:

Other:

Other services involved or referred to:

Home Care Package: Organisation: **Package level:**

Case Manager: Name: Phone:

Community services ☐ Domestic assistance ☐ Respite ☐ Personal Care ☐ Home maintenance ☐ Other

Allied health: (specify)

ACAS/ACAT: (specify)

My Aged Care: Referred ☐ No ☐ Yes **RAS assessment:** ☐ No ☐ Yes **MAC ID:** if known

Transitional Care Prog:

Other: