**Empower Healthcare Referral Form**

**TEMPORARY NURSING REFERRAL FORM**

**(ONLINE REFERRAL WILL BE AVILABLE FROM 15THMAY 2020)**

**NURSING SERVICES WILL BE AVAILABLE FROM THE 18TH OF MAY 2020**

**\*WE REQUIRE FULL MEDICAL HISTORY, MEDICATION SUMMARIES AND GP AUTHORISATIONS FOR NURSING REFERRALS\***

**INITIAL APPOINTMENT WILL BE 2 HOURS AND WILL INCLUDE IN REGION TRAVEL, INI AX, DOCUMENTATION & FIRST TREATMENT**

**Regularity:** One-Off Weekly Fortnightly Monthly Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Client Details:** | | | | | | |
| First Name: |  | | | Last Name: | |  |
| DOB: |  | | | Gender: | |  |
| Address: |  | | | | | |
| Suburb: |  | | | Postcode: | |  |
| Clients Mobile |  | | | Clients Landline: | |  |
| Notes re access to home: | | | | | | |
| Home Visit Safety: *Specify if you are aware of any issues that may impact on client, carer, or service provider safety.*  ***If there is a possibility of the Client or family member being aggressive toward the service provider, then the Case Manager must be present for appointments – aggressive or threatening behaviour will not be tolerated and if the service provider feels unsafe at any time they are well within their rights to leave the premises and refuse future treatment.*** | | | | | | |
| Emergency contact: |  | | | Phone: | |  |
| **Funding:** |  | | |  | |  |
| HCP: | Yes Level:  1  2  3  4 | | | | | |
| NDIS: | Yes NDIS Number:  Plan Managed:  Self-Managed:  NDIA Managed:  Email to send NDIS Service agreement: | | | | | |
| CDM/EPC: | Yes  No | | | If Yes – CDM attached? | | Yes  No |
| DVA: | Yes  No | | | If Yes | | White  Gold |
| Email for Invoice: |  | | |  | |  |
| **Referrer Inf:** |  | | |  | |  |
| Home Care Provider  NDIS Support Co-ordinator  Private  Other, please specify: | | | | | | |
| Organisation: | | | | | | |
| Full Address: | | | | | | |  | |
| Referrer Name: | |  | | Position: |  | |
| Phone: | |  | | Fax: |  | |
| Email: | |  | |  |  | |
| **Referral Details:** | | | | | | |
| Reason for Referral: | | | | | | |  |
| Relevant Medical History: | | | **Please provide as much medical history as possible – if you have medical history in a separate document please tick \*Attached box and email it along with this referral form.**  **PLEASE NOTE WE ARE UNABLE TO BOOK IN NEW CLIENTS WITHOUT DETAILS OF THEIR MEDICAL HISTORY**  \*Medical History attached: | | | |
| Client Risks: | | | Falls  Pressure Care  Medication  Allergies Carer Stress  Cognition/Memory  Malnutrition  Likely to present to hospital  Nil Identified  Other, please specify: | | | |
| Nursing Services Required | | | Oral medication  Diabetes Management  Woundcare  Catheter care  Continence  Other, please specify: | | | |
| Other Services already in Place: | | | Case Management  Personal Care  Community Nursing  Social Support  Respite  Domestic Assistance  Meal Delivery Services  Physiotherapy  Social Work  Transport Service  Palliative Care  Other, please specify: | | | |
| Further notes:  *Please provide further information if necessary* | | |  | | | |

**Consent to Referral:**

I have obtained verbal consent from the client/guardian to refer and provide their personal health information to Empower Healthcare for further assessment.

Referrer Name or Signature:

**Cancellation Policy:** *Empower Healthcare require 24 hours’ notice for any cancellations – clients will be charged full fee for anything under this time.*

**Disclaimer:** *Based on an assessment of your client Empower healthcare clinicians will make recommendations on services or products from third party organisations. Empower healthcare does not indemnify / guarantee third parties and does not take responsibility for the services or products purchased through these organisations.*

*By submitting to this referral to Empower Healthcare you are confirming you have consent to do so and have read and understood our above cancellation policy and disclaimer.*