Queensland Government

Wide Bay Hospital & Health Service
Bundaberg & Rural Health Service

Rural Allied & Community Health Referral Form

P.O. Box 41 Gayndah Qld 4625
Ph: 4161 3571 Fax: 4161 3598
E-Mail: Gayndah-CH-AH@health.qld.gov.au

URN:_____

Name:_____

Address:_____

_____

Contact Number:_____

Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F ☐ I

Parent / Carer:_____

Please note: Referrals should be directed to private providers for patients eligible for:

- Medicare team care arrangement
- Workcover
- NDIS
- Insurance claims
- Dept of Veteran's Affairs (DVA)
- FaHCSIA Helping Children with Autism/Better Start.

Medicare number: ..... Expiry Date: ...../.....

DVA number: ..... DVA type: .....

Does the client identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Does not identify

Is this referral a result of: ☐ WorkCover ☐ Motor Vehicle Accident

Referral from:		***Referral Date & Time***	...../...../..... ..... : .....
Referral for:	☐ Outpatient ☐ Inpatient ☐ MPHS aged care resident		

***Referral to:* Group Programmes**	***Referral to:* Specific Profession**	
☐ Cardiac rehabilitation	☐ Alcohol & other drugs	☐ Dietitian
☐ Pulmonary rehabilitation	☐ Exercise physiology	☐ Podiatry
☐ Chronic condition self-management	☐ Indigenous health worker	☐ Social Worker
☐ Chronic pain self-management	☐ Community nurse (adult)	☐ Physiotherapy
☐ Balance & mobility	☐ Occupational Therapy	
☐ Healthy eating group (eligibility: BMI >30kg/m^2 + co-morbidity)	☐ Speech Pathologist	
☐ Deadly Health Yarning (Aboriginal & Torres Strait Islander health group)	☐ Child Health / Antenatal / Postnatal	
	☐ Psychology (eligibility: referral related to chronic disease)	

Patient's preferred Hospital for appointment: .....

Is consent given by patient to receive text messages for appointments? ☐ Yes ☐ No

Does the patient give consent to sharing information with local providers & referrer? ☐ Yes ☐ No
(e.g. diabetes educator, Bluecare, IWC, RHealth, GP)

Home visit required? ☐ Yes ☐ No

Interpreter required? ☐ Yes ☐ No *Language*: .....

***Reason for referral*:**

Please include as much information as possible about your patient's condition to optimise their chances of being triaged correctly: e.g. diagnosis, duration, severity and impact.

Tests / Scans Completed: .....

Current Diagnosis / Condition + Reason for Referral: *(complete page 2 and 3 for co-morbidities and chronic conditions)*

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Onset Date of Condition/Injury: ..... / ..... / ..... **Symptoms less than 3 months?** ☐ Yes ☐ No

DO NOT WRITE IN THIS BINDING MARGIN

RURAL ALLIED & COMMUNITY HEALTH REFERRAL FORM

00062:RAH04 v4.00 01/2017 QHEPS

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Chronic Condition Pathway *(select one only)*

Complex Needs Service *(does your patient demonstrate any of the following?)*

- ☐ Unstable/poor controlled chronic disease
- ☐ Fragmented care due to involvement from multiple specialists
- ☐ A pattern of frequent hospital admissions
- ☐ Experience vulnerability due to poor psychosocial support/complex socioeconomic needs?

Additional information for the selected Complex Needs Service must be provided: .....

.....

.....

.....

.....

Please list details of any Medical Specialist or other health service provider:

Location/Facility: ..... Speciality: .....

Consultants name: ..... Next appointment date & time: ...../...../..... ..... : .....

Chronic conditions:

- ☐ Depression/social isolation
- ☐ Diabetes
- ☐ Previous cardiac event *(detail below)*
- ☐ Chronic pain
- ☐ Liver disease
- ☐ Polypharmacy
- ☐ Developmental concerns *(attach recent health checks)*
- ☐ Hyperlipidaemia
- ☐ Overweight/obesity
- ☐ Present falls
- ☐ Recent hospitalisation
- ☐ Social isolation
- ☐ Pulmonary condition
- ☐ Hypertension
- ☐ Physically inactive
- ☐ Balance issues
- ☐ Arthritis/osteoporosis
- ☐ Renal failure
- ☐ Metabolic syndrome
- ☐ Other

Additional Information: .....

.....

.....

.....

Cardiac & Heart Rehabilitation:

Can the patient tolerate a weekly exercise/education programme for 8 weeks? ☐ Yes ☐ No

☐ Medical clearance exercise rehabilitation form is attached for exercise and education programmes.

☐ This patient should attend the education programme only.

Clinical Syndrome:

	Date		*Date*
☐ STEMI	.....	☐ NSTEMI	.....
☐ PCI	.....	☐ Stent	.....
☐ CABG	.....	☐ Heart failure	.....
☐ Valve surgery	.....		

Name of hospital providing cardiac care: .....

Date of discharge: ..... ***Please attach discharge summary***

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Parent / Carer:_____

Pulmonary Rehabilitation:

Can the patient tolerate a weekly exercise/education programme for 8 weeks? ☐ Yes ☐ No

☐ Medical clearance exercise rehabilitation form is attached for exercise and education programmes.

☐ This patient should attend the education programme only.

Clinical Syndrome:

☐ COPD ☐ Chronic asthma ☐ Chronic bronchitis
☐ Emphysema ☐ Bronchiectasis ☐ Interstitial lung disease
☐ Stable angina ☐ Arrhythmias ☐ Other: .....

Is this patient on home oxygen?: ☐ Yes ☐ No

Additional Information: .....

.....

.....

.....

Diabetes Summary:

Diabetes Educator: ..... Podiatrist: .....

Hba1c history: .....

Blood results *(cholesterol etc.)* .....

Current Functional Status:

Has the patient had a recent change in mobility? ☐ Yes ☐ No

Mobility: ..... Assistance required: .....

Mobility aids: ..... WB status: .....

Current physical activity level: ☐ Low ☐ Moderate ☐ High

Toileting/incontinence: .....

Hygiene/showering/dressing: .....

Sensory impairment: ☐ Vision ☐ Hearing ☐ Speech ☐ Other: .....

Dementia: .....

Cognitive function: .....

Mental health: .....

Skin integrity: .....

Behaviour/pain/mood issues: .....

Communication: .....

Swallowing difficulties .....

Nutrition/diet/fluids .....

Carer's name: .....

Carer stress? ☐ Yes ☐ No

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RAHT USE ONLY

Chronic Condition Risk Calculator Part C Summary: *Refer to RAH5 for assessment calculator*

Level of Risk: ☐ Urgent *(score 39-49)* ☐ Medium *(score 11-23)*
☐ High *(score 24-38)* ☐ Low *(score 1-10)*

☐ Referral accepted **Prioritisation:** ☐ **1** ☐ **2** ☐ **3**

☐ Referral declined

Reason referral declined/ineligible: .....

.....

.....

Name: ..... Signature: ..... Date: .....

ADMINISTRATION USE ONLY

☐ Ineligibility letter ☐ Waitlist letter

☐ Phone Appointment ☐ 1st Appointment letter

☐ Date: ..... Time: ..... Location: .....

Client advised verbally of appointment? ☐ Yes ☐ No

DNA protocol discussed? ☐ Yes ☐ No

Name: ..... Signature: ..... Date: .....

Clinical notes prior to initial appointment:

Add signature, printed name, staff category, date & time to all entries.

DATE & TIME	

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