Western Health

## Western Continence Service

## Referral Form

Fax referral to 8345 0777

Hospital UR#...

Name: ...

Address: ...

Suburb: ...

Postcode: ... Telephone: ...

DOB:____/____/____ Marital Status: ...

Email Contact:

Referrers Name: ... Position: ... Tel / Page ...

Referring Hospital / Agency / Clinic: ... Unit: ... Ward: ...

Referred from: ☐ Acute Hospital ☐ Sub Acute / Rehab / GEM ☐ Community Agency ☐ Self / carer

☐ Emergency ☐ Hospice / Palliative Care ☐ Medical Specialist ☐ General Practitioner

If client is NOT being discharged to, or currently residing at their usual address, please specify alternative address: ...

... Tel: ...

Hospital Admission Date: / / Hospital Discharge Date: / / ☐ not applicable

Contact Person/Net of Kin: ... Tel: ...

Address: ... Work: ...

Relationship: ... Mobile: ...

Primary Carer: Yes ☐ No ☐

Case Manager: (if Relevant): ... Tel: ...

Agency: ... Mobile: ...

Reason for Referral: (External referrals please attach any additional information e.g. discharge summaries, investigations)

...

...

...

...

...

Incontinence: ☐ Urinary ☐ Faecal

☐ Recurrent UTI's ☐ Other: ...

Frequency of Problem: ...

Duration of Problem: ...

Other: ...

Previous Continence Assessment: ☐ Yes ☐ No ☐ By Whom ... Year ...

Requires:

☐ ISC Instruction ☐ Urodynamic Studies ☐ Pelvic Floor Physiotherapy ☐ General Continence Assessment

Relevant Medical/Surgical History: ...

...

...

...

...

...

...

Current Medications (attach medication list if available): ...

...

...

...

...

WHCOR29

Cognitive State:

☐ Normal ☐ Minor changes ☐ Confusion ☐ Dementia

Mobility:

☐ Independent ☐ Assisted ☐ Unable

Care Package:

☐ CACPS Linkages ☐ EACH ☐ EACH Dementia ☐ Other

Case Manager: .................................................. Telephone: ..................................................

Organisation: ..................................................

Address: ..................................................

New Referrals to other Agencies:

☐ RDNS ☐ ACAS ☐ Other

Has the patient consented to this Referral: ☐ Yes ☐ No

Contact Person for Appointments: .................................................. Tel: ..................................................

Address: .................................................. Work: ..................................................

Relationship: .................................................. Mobile: ..................................................

Any factors impacting on ability to attend a clinic appointment: ..................................................

..................................................

## COMPLETE BELOW FOR REFERRALS FROM OUTSIDE WESTERN HEALTH

GP Name: .................................................. Tel: ..................................................

Clinic Name: .................................................. Fax: ..................................................

Address: .................................................. Mobile: ..................................................

Is GP aware of Referral ☐ Yes ☐ No

Interpreter Required: ☐ Yes ☐ No Language: ..................................................

| **Carer Availability** | **Carer Relationship** | **Living Arrangements** | **Accommodation** |
|---|---|---|---|
| ☐ No Carer | ☐ Spouse/Partner | ☐ Lives Alone | ☐ Private (own/rent/purchase) |
| ☐ Co-resident Carer | ☐ Parent | ☐ Lives with Family | ☐ Outreach |
| ☐ Non Resident Carer | ☐ Child | ☐ Lives with Others | ☐ Supported Community |
| | ☐ Child-in-law | ☐ Not stated | ☐ Residential Aged Care |
| | ☐ Other Relative | | ☐ Residential Care Facility (not aged) |
| | ☐ Friend/Neighbour | | ☐ Short Term Crisis/Emergency |
| | ☐ Foster Carer | | ☐ Other Accommodation |

Country of Birth:

Aboriginal or Torres Strait Islander ☐ Yes ☐ No

Medicare No:

Pension No:

DVA No: (if applicable)

TAC ☐ Yes ☐ No Claim Number:

Workcover ☐ Yes ☐ No Claim Number: