|  |  |  |
| --- | --- | --- |
| **Client Details (Affix client details label if available)** | | |
| **Surname:** | **Given Names:** | |
| **Date of Birth:** | **Contact Number:** | |
| **Address:** | | |
| **Language:** | **Interpreter Required: Yes 🞏 No 🞏** | |
| **Copy of Advanced Health Directive or Statement of Choices is attached: Yes 🞏 No 🞏** | | |
| **Carer/Next of Kin:** | | |
| **Relationship to Client:**  Client is aware/Consent given of/for referral □ Yes □ No | | |
| **Mobile:** | | |
| **Email address:** | | |
| **Medical Practitioner’s Name:** | **Aware of referral: Yes 🞏 No 🞏** | |
| **Practice:** | | |
| **Phone: Fax: Mobile:** | | |
| **Current Community Services Involved:** | | |
| **ACAT Assessment Current: Yes □ No □ If yes, approvals in place for:** | | |
| **Medical Diagnosis:** | | |
|  | | |
|  | | |
| **Relevant Medical History:** | | |
|  | | |
|  | | |
| **Please attached medication list if available: Yes 🞏 No 🞏** | | |
| **Reason for Referral: End of Life Care 🞏 Symptom Management 🞏 Respite 🞏** | | |
| **Precautions required: Contact 🞏 Cytotoxic 🞏 Droplet 🞏 Airborne 🞏** | | |
| **Respiratory symptoms: Yes 🞏 No 🞏 COVID-19 testing: Yes 🞏 No 🞏** | | |
| **Allergies:** | | |
| **Current Diet:** | | |
| **Continence:** | | |
| **Mobility:** | | |
| **Equipment Needs:** | | **Approx weight:** |
| **Oxygen requirement: YES 🞏 NO 🞏** If yes, has concentrator/cylinders been arranged YES 🞏 NO 🞏 | | |
| **Other additional information:** | | |
| **Client is currently located (home, hospital):** | | |
| **Signature:** | **Date:** | |
| **Referral Name:** | **Phone:** | |
| **Referring Agency:** | **Email:** | |

For more information refer to our website frasercoasthospice.com.au or call 4334 0030

Please return completed form to [director@frasercoasthospice.com.au](mailto:director@frasercoasthospice.com.au) or fax 4334 0031