Queensland Government

Nurse Navigator Service Referral

Facility:

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

REASON FOR REFERRAL CRITERIA Please fax referral to:

Chronicity

☐ >6 months ☐ 3 or more chronic conditions

Complexity – in the last 12 months the patient has ...

☐ Required skilled care in all locations (home, school, work)
☐ Had 2 or more inpatient admissions LOS >10 days (unplanned)
☐ Had ≥10 outpatient contacts with HHS
☐ Had ≥6 Emergency Department presentations
☐ Had ≥10 outpatient contacts with PHNs
☐ Had ≥5 inpatient admissions (planned or unplanned)
☐ Had ≥2 readmissions within 28 days of discharge

Fragility

☐ Severe life threatening disease
☐ Equipment failure resulting in immediate risk
☐ Discharged against medical advice
☐ Risk of life threatening deterioration
☐ Risk of multiple FTAs to Specialist OPD

Fragility increased by:

☐ Geographical isolation
☐ Social complexity of significance
☐ Aged ≥65 yrs
☐ >50 for identifying A&TSI
☐ Culturally and linguistically diverse
☐ Child protection concerns
☐ Lower Literacy
☐ Lives alone
☐ Poor coping skills
☐ Low Health Literacy

Comments:

Intensity of Care

☐ Prolonged IV medication administration
☐ Dependence on medical aids e.g. O_2, suction, PEG, Parenteral Nutrition, non-invasive ventilation
☐ Partial or full dependence on carers for all ADLs
☐ Complexity requires increased daily nursing cares e.g. catherisations, multiple medications
☐ Pre and post operative high intensity of care

MARITAL STATUS

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

ETHNICITY

Are you of Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No
Were you born in a country other than Australia? ☐ Yes – which country:
Do you speak / understand English? ☑ Yes ☐ No
Interpreter required? ☐ Yes ☐ No Which language?

FAMILY DETAILS

Legal Guardian / Next of Kin / EPOA: ☐ Parents ☐ Other:

Name: Relationship:

Address:

Email Phone:

CLINICAL INFORMATION FOR REFERRAL

Medical diagnosis:

Pregnant? ☐ Yes ☐ No

The main purpose of the referral is for the patient to receive:

☐ Coordinated appointments
☐ Health coaching
☐ Improving health literacy
☐ Linkage to appropriate services
☐ Case coordination
☐ Establish regular review of patient goals
☐ Other (specify):

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NURSE NAVIGATOR SERVICE REFERRAL

v1.00 - 02/2016

SW656

Name DOB UR No

What do you see as a priority need for this patient/client and their family?

List medical concerns or planned surgery that requires additional care coordination:

Additional referral information
i.e. medical / family / care needs / other service providers (employer, day care, school, respite, family supports CHSP, ACAT assessed)

☐ Current inpatient – estimated discharge date: ☐ Outpatient

Hospital: Ward: Ph:

A member of this patient's care team already has care coordination type responsibilities?
☐ I am the care coordinator for this patient
Or name of Coordinator: Role:

Ph: Email:

Please provide details of the other professionals involved in the care of this patient:

Name	Role	Phone	Email

REFERRAL SOURCE

Name: Designation:

Agency / Provider / Organisation address: **Signature:**

Ph:

Email: Date:

Please attach copies of:
☐ Recent clinical letters ☐ Discharge summaries ☐ Acute Management Plan
☐ Relevant social / clinical documentation (i.e. Child Protection orders, Family Law Court documents, Disability referral services, ACAT assessments, Advance Health Directice, ARP, EPOA

Thank you for your referral. Please email or fax this information to:

INTAKE AND ACCESS PURPOSES ONLY

Date received: ☐ Accepted ☐ Not accepted ☐ Referrer notified

Processed by: ☐ HBCIS registration and Nurse Navigator Service Alert

Name: **Signature:**

Designation: **Date:**

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