		_	
	(Affix patient identification label here)		
	URN:		
Queensland Government	Family Name:		
Nurse Navigator Service	Given Names:		
Referral	Address:		
Facility:	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, was Had 2 or more inpatient admissions LOS >10 days (to Had ≥10 outpatient contacts with HHS Had ≥6 Emergency Department presentations			
Fragility			
Equipment failure resulting in immediate risk Ri Discharged against medical advice Fragility increased by:			
Intensity of Care ☐ Prolonged IV medication administration ☐ Dependence on medical aids e.g. O₂, suction, PEG, ☐ Partial or full dependence on carers for all ADLs ☐ Complexity requires increased daily nursing cares e.g. ☐ Pre and post operative high intensity of care			
MARITAL STATUS			
Single Partnered Married Separated	Divorced Widowed	72	
ETHNICITY			
Are you of Aboriginal or Torres Strait Islander origin? Were you born in a country other than Australia? Do you speak / understand English? Interpreter required? Yes No Which language	Yes No Yes – which country: Yes No ?		
FAMILY DETAILS		Ì	
Legal Guardian / Next of Kin / EPOA: Parents	Other:		
Name:	Relationship:	_ <u>-</u> 	
Address:			
Email	Phone:	_ { _ {	
CLINICAL INFORMATION FOR REFERRAL			
Medical diagnosis:			
Pregnant? Yes No The main purpose of the referral is for the patient to Coordinated appointments Health coaching Linkage to appropriate services Case coordination	Improving health literacy		
Linkage to appropriate services Case coordinati Other (specify):	on Lacabilish regular review of patient goals		

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Name		DOB		UR No					
What do you see as a priority	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 / or		plover day care scho	ol respite family si	innorts CHSP ACAT assessed)					
i.e. medical / lamily / care needs / o	ther service providers (em	pioyer, day care, scrio	or, respire, raining so	apports of for , AOAT assessed)					
Current inpatient – estimated	I discharge date:	Outpatient							
Hospital:		Ward:	Ph	1:					
A member of this patient's care		coordination type re	esponsibilities?						
I am the care coordinator for Or name of Coordinator:	this patient		Role:						
Ph:	Email:								
Please provide details of the		volved in the care	of this patient:						
Name	Role	Phone Email							
REFERRAL SOURCE									
Name:		Desigr	nation:						
Agency / Provider / Organisation	n address:			nature:					
Ph:									
Email:	y.								
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 PURPO									
Date received:	Accepted	Not accepted	Referrer notified						
Processed by:	cessed by: HBCIS registration and Nurse Navigator Service Alert								
Name:			-	Signature:					
Designation:		Date:							