



**Queensland  
Government**

Central Queensland Hospital and Health Service

**Sub Acute Chronic Care  
Rehabilitation (SACCR) Service  
Referral Form**

Facility / Unit: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Phone:

Date of birth:

Sex:  M  F  I

Please send completed referral to the Sub Acute Chronic Care Rehabilitation Service via  
**Fax: 07 4932 5294 OR Email: [cqhssaccradmin@health.qld.gov.au](mailto:cqhssaccradmin@health.qld.gov.au)**  
For further questions please call 4930 9009.

**IMPORTANT:**

**To be eligible for the SACCR Pathway, in addition to Pathway Inclusion Criteria the patient MUST:**

- Be over 18years and willing to participate
- Have a specific chronic diagnosis that fits within Cardiac, Respiratory, Diabetes, Venous Compression, Falls & Balance, Neurological or Complex Spinal Pain pathway
- Require assistance from 2 or more clinicians
- Have a recent hospital admission (within 3 months) OR Multiple hospital re-admissions OR are at High risk of hospital admission
- Not live in a nursing home
- Not be utilising NDIS or DVA or EPC for similar services

**To be eligible for the Emergency Department SACCR Assessment Service, in addition to Service Inclusion Criteria the patient MUST:**

- For medication review, to be referred by Rockhampton Hospital Emergency Department (Medical Officer/Nurse Practitioner) or Pharmacy Department

**REFERRAL INFORMATION**

**1. SACCR Pathway referred to (based on Pathway Inclusion Criteria): SELECT ONE ONLY**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cardiac - Phase 3 (from Phase 2 referral only)        | <input type="checkbox"/> Respiratory     | <input type="checkbox"/> Venous Compression             |
| <input type="checkbox"/> Cardiac - Heart Protection Program (Per CPAS Pathway) | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Complex Spinal Pain            |
| <input type="checkbox"/> Cardiac - High Risk (Community patients only)         | <input type="checkbox"/> Falls & Balance | <i>(Rockhampton Hospital<br/>Orthopaedic Dept only)</i> |
| <input type="checkbox"/> Neurological  |  |   |

**2. SACCR Assessment Service (based on Inclusion Criteria): For Use by Emergency Department or Pharmacy ONLY**

- Pharmacy Medication Review       Others

**REASON FOR REFERRAL**

Include any relevant medical and psychosocial history:

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**PATIENT DISCHARGE INFORMATION**

**Please attach the following relevant documentation:**

- Discharge summary     Medication summary     Pathology/imaging results     Other \_\_\_\_\_

**PATIENT GP INFORMATION**

GP Name (please print):..... Contact Number: .....

**REFERRER INFORMATION**

Referrer Name (please print):.....

Designation: .....

Signature: .....

Date:.....

Contact Number:

.....

Service/Facility:

.....

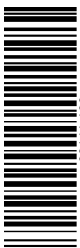
**OFFICE USE ONLY**

Comments (if relevant)

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All clinical forms creation and amendments must be conducted through Health Information Unit

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SACCR REFERRAL