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: cghhssaccradmin@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 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*

☐Cardiac - Phase 3 (from Phase 2 referral only)
☐Cardiac - Heart Protection Program (Per CPAS Pathway)
☐Cardiac - High Risk (Community patients only)
☐Neurological
☐Respiratory
☐ Diabetes
☐Falls & Balance
☐ Venous Compression
☐ Complex Spinal Pain *(Rockhampton Hospital Orthopaedic Dept only)*

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)	

DO NOT WRITE IN THIS BINDING MARGIN

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

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SACCR REFERRAL