Confidential Referral Cover Sheet

Date Sent: dd/mm/yyyy / /

Number of Pages (including cover sheet):

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Referral to

Name:

Position:

Organisation:

Phone:

Fax:

Email address:

Address:

Agency/Service Provider sending referral

Name:

Position:

Organisation:

Phone:

Fax:

Email address:

Address:

Priority

This referral is:	☐ Low	☐ Routine	☐ Urgent	☐ Renewal (ACAS)
	hold over during peak demand	*attend in date order (this may include the consumer being placed on a waiting list)*	*cannot wait*	*For ACAS Assessment*

List of Attachments: **(please tick relevant box(es))**

Consumer Information (required)	Summary and Referral (required)	☐ Consumer Consent
☐ Need for Assistance	☐ Living and Caring Arrangements Profile	☐ Health Behaviours Profile
☐ Health Conditions Profile	☐ Psychosocial Profile	☐ Functional Assessment Summary
☐ Family and Social Network Profile	☐ Care Coordination Plan	☐ Palliative Care Supplement

☐ Other: _____

Other notes:

Referral Acknowledgement

Please be advised that the above referral has been received and: *(Please tick appropriate box)*

☐ **The referral is accepted**. Estimated date of consumer assessment dd/mm/yyyy / /

or

☐ **The referral is not proceeding** for the following reason(s):

☐ Consumer (or consumer's representative) declining	☐ Waiting list time inappropriate for consumer	☐ Ineligible for services	☐ Inappropriate referral	☐ Other

Comments and any further actions undertaken:

Date Acknowledged: dd/mm/yyyy / / Name: Position:

Produced by the Victorian Department of Human Services, 2009

Consumer Consent to Share Information

To record freely given informed consumer consent to share their information with a specific agency/ies for a specific purpose/s.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Section 1: Proposed Information Uses and Disclosures

Service Type Examples: – Physiotherapy – Specialist consultant	Name of Agency Examples: – Any agency – Nominated clinic	Type of Information *(including limits as applicable)* Examples: – All relevant information – Test results only	Purpose/s Examples: – Referral – Care coordination

Section 2: Record of Consumer Consent

2(a) Written Consumer Consent Or

The worker/practitioner has discussed with me how and why certain information about me may be shared with other service providers. I understand this and I give my informed consent for the information to be shared as detailed above.

Signed:

Dated: dd/mm/yyyy / /

Signed by:

☐ Consumer OR

☐ Authorised representative on behalf of:

(Consumer)

Witnessed by:

Signed:

(Worker/Practitioner)

Dated: dd/mm/yyyy / /

Worker/Practitioner Name:

Position:

2(b) Verbal Consumer Consent

Worker/Practitioner Use Only

Verbal consent should only be used where it is not practicable to obtain written consent.

I have discussed with the consumer/consumer's authorised representative how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent for the information to be shared as detailed above has been given.

Signed:

(Worker/Practitioner)

Dated: dd/mm/yyyy / /

Worker/Practitioner Name:

Position:

To ensure the consumer/consumer's authorised representative is able to make an informed decision about consent to the sharing of information as detailed above, the worker/practitioner should: (tick when completed)

1. Discuss with the consumer the proposed sharing of information with other services/agencies ☐
2. Explain that the consumer's information will only be shared with these services/agencies if the consumer has agreed and, when referring, advise that referral for service can still proceed if the consumer does not want information disclosed ☐
3. Provide the consumer with information about privacy, such as the brochure *'Your Information – It's Private'* ☐
4. Provide the consumer with a copy of this form if requested (see guidelines) once completed ☐

Produced by the Victorian Department of Human Services, 2009

This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Consumer Information

To collect common demographic and other essential consumer information that can be shared with another agency.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Consumer Details

Family Name:

Given Names:

Preferred Name/s:

Date of Birth: dd/mm/yyyy / /

Is the date of birth estimated? **Code:**

Sex: **Code:** **Title:**

Home Address

Post code:

Postal Address (if different from above)

Post code:

Contact phone number/s *(tick preferred number)*

Can leave message?

☐ Home: ( )	☐ Yes	☐ No
☐ Work: ( )	☐ Yes	☐ No
☐ Mobile:	☐ Yes	☐ No
☐ Email:	☐ Yes	☐ No

Country of Birth: **Code:**

Indigenous Status: **Code:**

Need for Interpreter Services: **Code:**

Preferred Language: **Code:**

Communication Method: **Code:**

General Practitioner

GP Name:

Practice Name:

Address:

Phone:

Fax:

Email:

Who the Agency Can Contact if Necessary

(e.g. carer, parent, case manager, next of kin, guardian, friend, emergency contact)

Person 1 Name:

Contact Address

Post code:

Phone numbers

Home:

Work:

Mobile:

Relationship to Consumer: **Code:**

Is this person the consumer's carer? **Code:**

Is this person the person who makes the consumer's legal decisions? **Code:**

Person 2 Name:

Contact Address

Post code:

Phone numbers

Home:

Work:

Mobile:

Relationship to Consumer: **Code:**

Is this person the consumer's carer? **Code:**

Is this person the person who makes the consumer's legal decisions? **Code:**

Legal Orders: **Code:**

Government Pension/Benefit Status: **Code:**

Health Care Card Holder Status: **Code:**

Card number:

Medicare Card:

Card number:

Health Insurance Status:

Insurer name:

Card number:

DVA Card Entitlement:

DVA card type: **Code:**

DVA card number:

Compensables Funding Source: **Code:**

Comments:

Produced by the Victorian Department of Human Services, 2009

This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Summary and Referral Information

To record and share a summary of the consumer's problems/issues, provide information to indicate eligibility, and an initial action plan when making a referral.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Presenting Issue(s) as Identified by Consumer:

Reason for Referral:

Description of issues as identified by the Initial Needs Identification (INI)

Current presentation/episode; presenting problem(s) – observed or described features; screening evidence:

Significant Histories/Recent and past history (medical, developmental, functional/daily living skills, social, emotional etc.):

Medications:

Other:

Alerts

Allergies:

Risks: (see code sets) Code:

Additional comments including urgency:

Produced by the Victorian Department of Human Services, 2009

This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Summary and Referral Information

To record and share a summary of the consumer's problems/issues and an initial action plan when making a referral.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Current Services

Record services used in the last twelve months. Consider all health and community services.

Agency	Service Type Code:	Record contact details or other information as appropriate

Referral Action Plan

Taking into account the reason/s that the consumer is seeking services and any other issues you and the consumer have subsequently identified, summarise the action required.

Date Referral/s Sent: dd/mm/yyyy / /

Agency	Service Type Code:	Phone Number	Purpose of Referral	Consumer Consent Code:	Referral Method Code:	Feedback to

Summary and Referral Information