Australian Government

myagedcare

FOR PATIENT IDENTIFICATION LABEL ONLY

My Aged Care Hospital Fax Referral Form

Important:

- Complete all relevant sections. Fax only one patient referral at a time and please only send one referral per patient.
- Use this form for referring patients to My Aged Care for access to the Commonwealth Home Support Programme or for referring directly to the ACAT for accessing services under the Aged Care Act (including Home Care Packages, Residential Care and Transition Care)
- If you are sending this referral form to My Aged Care, please consider using the online form for faster and more efficient outcomes for patients. Confirmation of receipt will also be provided when using the online form.

Fax the completed form to My Aged Care: 1800 728 174

Note. This referral does not guarantee access to services. Provision of services will be dependent on service availability in the area and the client's specific needs.

Referrer Details* (*denotes a section that must be completed)			
Name of Referrer:	Click in shaded areas only	**Referrer Ph:**	
Hospital Name:			
Hospital Address:			

Patient Details*			
First Name:		**Last Name:**	
Gender:		**DOB** (dd/mm/yyyy):	dd / mm / yyyy
Home address:			
Can the patient be contacted by phone?	☐ Yes ☐ No	**Patient Ph:**	
Medicare Card#: (including IRN)		**DVA Card #:**	
		DVA Card Colour:	☐ Gold ☐ White ☐ Orange
Is your patient of Aboriginal or Torres Strait Islander origin?	☐Aboriginal ☐Torres Strait Islander ☐Both ☐Neither ☐Unknown		
Interpreter Required:	☐ Yes ☐ No	**Specify Language:**	

Discharge details: (if different from home address)	**Phone:**	
	Details:	☐ Respite ☐ Family members Other:
	Address:	
Discharge Date (expected, dd/mm/yyyy)	dd / mm / yyyy	

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Patient Name :_____

Consent For Referral* This section must be completed for the referral to be actioned

Consent to make this referral also includes consent from the patient to have their personal information stored within My Aged Care, and for it to be provided to relevant assessment organisations, service providers and health professionals, and consent to share information back with you (the referrer) about the referral.

Has consent been provided for this referral?	☐ Yes ☐ No

If not patient, consent provided by:		**Ph:**	
Relationship to the Patient:			
Reason if not the Patient:			

Additional Patient Information

Does the patient have a carer/support person?	☐ Yes ☐ No
Usual Living Arrangements:	☐ Alone ☐ With Family/Partner/Carer ☐ Homeless Other:

Details of Carer/Support person 1:	Relationship to the Patient:	☐ Partner ☐ Child ☐ Parent ☐ Neighbour/Friend Other:		
	Name:		Ph:	
	Address:			
Do they need to be present at any aged care assessments?			☐ Yes ☐ No	

Details of Carer/Support person 2:	Relationship to the Patient:	☐ Partner ☐ Child ☐ Parent ☐ Neighbour/Friend Other:		
	Name:		Ph:	
	Address:			
Do they need to be present at any aged care assessments?			☐ Yes ☐ No	

GP Details:	Name:		Ph:	
	Practice name:			

Post-Acute Services/Care Details Please complete if client has also been referred to Post-Acute Care

Has the patient been referred to a post-acute care program?		☐ Yes ☐ No		
Provider:	Provider name:		Provider Ph:	
	Services provided:		Duration of service:	weeks

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Why The Patient Is Seeking Services Or Requires An Assessment*

Description of problem or issue as identified by the referrer or patient, for example relevant medical conditions, reason for admission, mobility, fall risk or cognition issues.

Click to add text

Patient Concerns*

Are there concerns with any of the following? Please select all that apply

- ☐ **Health concerns impacting independence**
- ☐ **Recent falls**
- ☐ **Pain**
- ☐ **Weight loss or nutritional concerns**
- ☐ **Feeling lonely, down or socially isolated**
- ☐ **Memory loss or confusion**
- ☐ **Risks, hazards or safety concerns in their home**
- ☐ **Special needs**

Patient Function*

Based on your knowledge is the patient able to:

	Without help	With a little help	With a lot of help	Completely unable	Not known
Get out of bed or chairs easily?	☐	☐	☐	☐	☐

	Without help	With some help	Completely unable	Not known
Eat their meals?	☐	☐	☐	☐
Go to the toilet?	☐	☐	☐	☐
Walk easily?	☐	☐	☐	☐
Shower or have a bath?	☐	☐	☐	☐
Manage their own medications?	☐	☐	☐	☐
Travel in the community?	☐	☐	☐	☐
Go shopping for groceries?	☐	☐	☐	☐
Prepare their own meals?	☐	☐	☐	☐
Do housework?	☐	☐	☐	☐
Get Dressed?	☐	☐	☐	☐
Manage their money?	☐	☐	☐	☐

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Patient Function*

Based on your knowledge is the patient able to:

Patient Function: How can you use this information?

If you have answered "without help" for most functions and "some/a little help" for a few functions, the patient may benefit from access to one or more Commonwealth Home Support Programme (CHSP) services. Access to these services would be determined by an assessment undertaken by a Regional Assessment Service (RAS).

If you have answered "with a lot of help" or "completely unable" for a number of functions, the patient may benefit from more extensive support such as a Home Care Package or may benefit from Residential/Respite Care or Transition Care. Access to these programs would be determined by an assessment undertaken by an Aged Care Assessment Team (ACAT).

Recommendation*

I want to recommend my patient for:

☐	**Comprehensive assessment by an Aged Care Assessment Team (ACAT)**	Complete section A	*Recommended if your patient has lower levels of function and would benefit from access to a Home Care Package, Transition Care or Residential Care*
☐	**Home support assessment by the Regional Assessment Service (RAS)**	Complete section B	*Recommended if your patient has higher levels of function and would benefit from access to CHSP services*

Section A: Recommended for ACAT Assessment

Please complete and fax to your local ACAT

To support aged care assessment, please specify the aged care programs your patient would benefit from:

☐ Residential Care ☐ Residential Respite ☐ Transition Care Program ☐ Home Care Package

Location of Assessment	☐ Hospital ☐ Usual residence
	Other (please specify):

Section B: Recommended for RAS Assessment (CHSP Services)

Please complete and fax to My Aged Care 1800 728 174

To support aged care assessment, please specify the types of services the patient would benefit from:

☐ Community Nursing	☐ Transport	☐ Meals
☐ Personal Care	☐ Domestic Assistance	☐ Home Modifications

Allied Health, please specify:	
Other, please specify:	
Estimated duration of services:	☐ Short term (< 6 weeks) ☐ Medium term (6 – 12 weeks) ☐ Long term (> 12 weeks)
Date Services Required:	

Additional Information

Have you attached relevant case information including allied health assessments, wound care details, discharge summaries, care plans or relevant medical summaries? (please do not fax the client file)	☐ Yes ☐ No

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Additional Information

Other comments: