SOUTH EASTERN SYDNEY
ILLAWARRA
NSW HEALTH

Facility:

ACCESS AND REFERRAL INTAKE

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SEI010.408

Referrer Details

Referred By (Name):	Contact No:
Designation / Organisation / Relationship:	
Ward:	Hospital:
In Hospital Assessment: Yes ❑ No ❑	AMO Details:
Hospital Discharge Date:	Date of Referral:
Date Service to Commence:	Medical / Nursing Discharge Summary attached: ❑
Is the Patient / Carer Aware of Referral: Yes ❑ No ❑	Does the Patient Consent to referral: Yes ❑ No ❑

Patient / Client Details

Surname:	Given Names:
DOB:	Male ❑ Female ❑
Marital Status: Married / De facto ❑ Never Married ❑ Separated ❑ Divorced ❑ Widow ❑ Unknown ❑	
Mothers Given and Surname (C & F referrals only):	
Temporary / Discharge Address:	
Suburb:	Home No:
Work No:	Mobile No:
Permanent Address:	
Suburb:	Home No:
Aboriginal or Torres Strait Islander Descent? ❑ No ❑ Yes Please specify → ❑ Aboriginal ❑ Torres Strait Islander ❑ Both	
Country of Birth:	Religion:
Preferred language:	Interpreter required: Yes ❑ No ❑

GP Details

GP Name:	
Phone No:	Fax No:
Address:	
Suburb:	Is GP aware of referral: Yes ❑ No ❑

Person to Contact Details

Contact Name:	
Relationship to Patient:	
Carer: Yes ❑ No ❑	Mobile No:
Home No:	Work No:
Address:	

Financial Details

Medicare No: __ __ __ __ __ __ __ __ __ __ / __	Medicare Ineligible: Yes ❑ No ❑
DVA No:	Card Colour: Gold ❑ White ❑
Pension Type: Aged ❑ Disability Support ❑ Carer ❑	

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Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING

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Diagnosis/ Medical History: *(include any other relevant details – co-morbidities, test results)*

Multi-Resistant Organism and/or Infection Alert: No ❑ Yes ❑ Type/ Site: _____

Biohazard Alert:

Allergies:

Service Requested/ Patients Needs: *(description of problem and/ or issue, including current management/ treatment)*

Hospital Discharge ❑ Falls ❑ Acute Medical Condition ❑ Carer Burden ❑ Increasing Frailty ❑ Other ❑

Other Referrals Made: *(include services and contact details)*

Other Community Services Already Received: *(include services and contact details)*

Current ACCR Yes ❑ No ❑ High Level ❑ Low Level ❑ Respite ❑ CACP ❑ EACHP/D ❑

Communication Impairment:	**Cognition:**	**Mobility:**	**Personal Risk Assessment:**
Speech: Yes ❑ No ❑	Orientated Yes ❑ No ❑	❑ Independent	Verbally threatening: Yes ❑ No ❑
Hearing: Yes ❑ No ❑	**Confused:**	❑ Independent with aid	Acts of aggression: Yes ❑ No ❑
Vision: Yes ❑ No ❑	New ❑ Old ❑ Deterioration ❑	❑ Assist x 1	Sexual harassment: Yes ❑ No ❑
Aids:	**Dementia Diagnosis:**	❑ Wheelchair	Other:
	Yes ❑ No ❑	❑ Bed bound	

Social:	**Palliative Diagnosis:**	**Continent:**
Lives Alone: Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑
Does the patient have a carer: Yes ❑ No ❑	End Stage Yes ❑ No ❑	SPC ❑ IDC ❑ N/A ❑
Is carer in hospital or away: Yes ❑ No ❑	Diagnosis:	Self Caring Yes ❑ No ❑
Relationship: _____		
Is the patient a carer: Yes ❑ No ❑		

Transport Required: Yes ❑ No ❑ | Is patient able to: Get in/ out of car ❑ On/ off bus ❑ Stretcher required ❑

Ambulatory Care Unit AMO Only: AMO _____ Date: _____

Requesting M.O Signature: _____ Print Name: _____

OFFICE USE ONLY

Service:	Case Manager:	Date Received:

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