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Canberra Health Services

# Patient Information and Referral Form CHI

**CHI Phone:** 5124 9977 **Fax:** 5124 1082

**Complete details or affix label**

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

## Consumer Details:

Title: _____ Given Names: _____ Surname: _____

**Usual Address:** _____

Phone: H: _____ Mob: _____

**Message authorisation:** ☐ Home ☐ Mobile ☐ SMS

**Service Address and Phone** (if different from above):

Address: _____

Phone / Mob: _____

## Baby's Details

Name: _____ Gender: ☐ M ☐ F D.O.B.: _____/_____/_____

## ☐ Next of Kin ☐ Emergency Contact Details ☐ Power of Attorney

Name: _____ Relationship: _____

Phone: H: _____ Mob: _____

**Message authorisation:** ☐ Home ☐ Mobile

Name: _____ Relationship: _____

Phone: H: _____ Mob: _____

**Message authorisation:** ☐ Home ☐ Mobile

## Demographic Details:

Country of Birth: _____

Interpreter: ☐ Yes ☐ No Language Spoken: _____

Identifies as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

**Living Arrangements**

☐ Alone
☐ Family
☐ Other: _____

**Accommodation Setting**

☐ Private Own
☐ Private Rental
☐ Public Housing
☐ Other (specify): _____

**Funding type (if applicable)**

Medicare number: _____
☐ Centrelink Pension
☐ Commonwealth Home Support Program (CHSP)
☐ National Disability Insurance Scheme (NDIS)
☐ Health Care Card
☐ Vets Affairs GOLD
Number: _____
☐ Compensable
Claim No: _____
☐ Commonwealth Home Care Package
Level: ☐ 1 ☐ 2 ☐ 3 ☐ 4

## Medical Practitioner:

GP (name): _____ Phone: _____

Specialist (name): _____ Phone: _____

**Alerts / Allergies:**

**Other Alerts:** (Behavioural, Environmental)

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**Complete details or affix label**

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

**Hospital Admission Date:** ___/____/____ **Expected Discharge Date:** ___/____/____

**Reason for hospital admission / Clinical issue:** _____

| | Services Requested | Clinical Reason for Services |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

**Consent from consumer obtained?** ☐ Yes ☐ No

**Waterlow Risk Assessment Score:** ☐ At Risk = 10 ☐ High Risk = 15 ☐ Very High Risk = 20+

☐ **Specific Medical Instructions:** _____

☐ **Additional Documentation Attached**

☐ Treatment Orders ☐ Medical Officer Orders for Medication Administration

☐ Catheter Management ☐ Other: _____

**Referrers Details** (*please print clearly*):

Referral Agency: _____ Contact Name: _____

Phone/Mobile: _____ Fax: _____

Email: _____

Signature: _____ Date: ____/___/____

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**Complete details or affix label**

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

**Current Relevant Clinical History:**

**Past Medical History:**

**Social Details:**

## Other Services:

**Was the consumer receiving any services prior to hospital admission?** ☐ Yes ☐ No ☐ N/A
If yes please list services below

| **Other Services** (not provided by Canberra Health Services) | **Agency** |
|---|---|
| | |
| | |

**Have referrals been made to other services post discharge?** ☐ Yes ☐ No
If yes please list services below

| **Other Services** (not provided by Canberra Health Services) | **Agency** |
|---|---|
| | |
| | |

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