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| Canberra Health Services  **PATIENT INFORMATION AND REFERRAL FORM CHI - ENOTE**  **CHI Phone:** 5124 9977 **Fax:** 5124 1082 | **URN:**  **Family name:**  **Given names:**  **Date of Birth:**       **Sex:** |
| **Consumer Details:**  Title:Given Names:Surname:  Usual Address:  Phone (home):  Phone (mobile):  **Message Authorisation:** HomeMobile SMS  **E**mail  **Service Address and Phone** (if different from above)  Address:  Phone / Mobile:  Email:  **Baby’s Details**  Name:Gender: Date of Birth: | |
| **Next of Kin**  **Emergency Contact Details**  **Power of Attorney**  Name:Relationship:  Phone (home):  Phone (mobile):  **Message Authorisation:** HomeMobile  Name:Relationship:  Phone (home):  Phone (mobile):  **Message Authorisation:** HomeMobile | |
| **Demographic Details:**  Country of birth:  Interpreter: Yes NoLanguage Spoken:  Identifies as: AboriginalTorres 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 Number:  Commonwealth Home Care Package  Level: 1 2 3 4 |
| **Medical Practitioner:**  GP Name:       Phone:  Specialist Name:       Phone: | |
| **Alerts / Allergies:** | **Other Alerts**(Behavioural, Environmental): |
| **Hospital Admission Date:** | **Expected Discharge Date:** |
| **Reason for hospital admission / Clinical issue:** | |
| **Services Requested** | **Clinical Reason for Services** |
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| **Consent from consumer obtained?** Yes No  **Waterlow Risk Assessment Score:** At Risk = 10 High Risk = 15Very High Risk = 20+ | |
| **Specific Medical Instructions:** | |
| **Additional Documentation Attached**  Treatment Orders  Catheter Management | Medical Officer Orders for Medication Administration  Other |
| **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** |
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**Have referrals been made to other services post discharge?** Yes No

If yes, please list services below.

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| **Other Services** (not provided by Canberra Health Services) | **Agency** |
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| **Referrers Details**  Referral Agency:       Contact Name:  Phone / Mobile:  Fax:  Email:  Signature: ElectronicDate: | |