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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:** [ ] Home[ ] Mobile [ ] 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:** [ ] Home[ ] MobileName:Relationship:Phone (home):  Phone (mobile): **Message Authorisation:** [ ] Home[ ] Mobile |
| **Demographic Details:**Country of birth:      Interpreter: [ ] Yes [ ] NoLanguage 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 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**1.
 | **Clinical Reason for Services**      |
| 1.
 |       |
| 1.
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| 1.
 |       |
| **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 [ ] 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/AIf 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.

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