GIPPSLAND SOUTHERN Health Service

(Place Patient Label Here)

Unit Record No _____
Surname _____
Given Name _____
Address _____
Phone _____
D.O.B _____ Sex _____

SUB ACUTE/MAINTENANCE CARE REFERRAL

SUBACUTE CARE REFERRAL MR 020

Referrer's Details

Hospital/Agency:_____ Date of Referral:_____

Ward/Unit:_____ Contact Person:_____

Contact Phone:_____ Fax:_____ Email:_____

Reason for Referral:_____

When will patient be ready for transfer? ❑ ASAP ❑ Within a week ❑ Within a month ❑ More than a month

Diagnosis/Medical History:_____

_____

_____

Past Medical/Psych History:_____

_____

_____

Allergies/Sensitivities/Reactions:_____

Do they have private health insurance? ❑ No ❑ Yes – details:_____

Does this person need rehabilitation? ❑ No ❑ Yes – details:_____

Does this person need maintenance care? ❑ No ❑ Yes – details:_____

Does this person need nursing home care? ❑ No ❑ Yes – details:_____

Infection Control

Does the patient exhibit:

- ❑ Copious drainage from a wound or abscess
- ❑ Diarrhoea
- ❑ Incontinence of bowel
- ❑ Skin shedding lesions
- ❑ Urinary catheter
- ❑ Uncontained sputum/urine
- ❑ Non-compliance with infection control practices
- ❑ Immunosuppression
- ❑ Invasive devices
- ❑ Was recently overseas in a country with endemic multi resistant organisms

Consent

Is the client aware of this referral? ❑ Yes ❑ No

If "no", why?_____

Does the client understand what Maintenance Care is? ❑ Yes ❑ No

If "no", why?_____

Does the client agree to participate in a Maintenance Care Program and had it explained and consent signed? (as attached)

❑ Yes ❑ No – if "no", why?_____

Client Details

Country of Birth:_____ Language spoken at home:_____

Next of Kin's Name:_____ NOK's Phone:_____

Skin Integrity

❑ Intact ❑ Broken – if "broken" location:_____

Aetiology:_____

Current management:_____

Wound swab results:_____

Pressure injury grade: ❑ 1 ❑ 2 ❑ 3 ❑ 4

Social/Family Supports

Lives with: ❑ Alone ❑ Family ❑ Friends ❑ Attendant ❑ Other_____

Supports: ❑ Meals on Wheels ❑ Home Help ❑ Carer ❑ Community/DNS/Private Nursing

❑ Other_____ ❑ Case Manager Name:_____

Comments:_____

Elimination

Urine: ❑ Continent ❑ Incontinent ❑ Catheter ❑ Suprapubic Catheter

❑ Nephostomy ❑ Ileal Conduit ❑ Other_____

Bowel: ❑ Continent ❑ Incontinent ❑ Colostomy ❑ Ileostomy ❑ Suppositories/aperients

Aids used:_____ Incidents/accidents in past fortnight:_____

Functional Status

Weight Bearing: ❑ Non weight bearing ❑ Touch weight bearing ❑ Partial weight bearing

Rationale/Length of time: _____

❑ Weight bear as tolerated ❑ Full weight bearing

Transfers:	Bed mobility:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
	In/out of bed:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
	In/out of chair:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
	Mobility:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent

Aids:_____ Endurance: ❑ <17m ❑ >50m

Has own equipment: ❑ Yes ❑ No

Activities of Daily Living:

Grooming:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
Bathing:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
Dressing: Upper body:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
Dressing: Lwr body:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent
Toiletting:	❑ Independent	❑ Supervised	❑ Assisted	❑ Dependent

Other functional matters:_____

Falls history:_____

Current falls risk rating:_____

Medication list:_____

Pain: ❑ Acute ❑ Chronic

❑ Palliative – describe management plan and effect:_____

Cognition/Behaviour

Short term memory:	❑ Impaired	❑ Not impaired
Insight:	❑ Impaired	❑ Not impaired
Confused:	❑ Yes	❑ No
Comprehension:	❑ Impaired	❑ Not impaired
Expression:	❑ Impaired	❑ Not impaired
Social Interaction:	❑ Impaired	❑ Not impaired
Problem solving:	❑ Impaired	❑ Not impaired
Wandering:	❑ Yes	❑ No
Restless/Agitated:	❑ Yes	❑ No
Psychosocial Issues:	❑ Yes	❑ No

Mini mental score: _____

Comment on capacity to improve:_____

Nutrition

Weight:_____ BMI:_____

Dietitian Referral/Report: ❑ Yes ❑ No

Feeding: ❑ Independent ❑ Supervised ❑ Assisted ❑ Dependent

❑ Enteral feeding eg NGT, PEG ❑ Modified food/fluids specify:_____

Enteral feeding diet:_____

Speech

Speech Pathologist Name:_____

Referral Sent: ❑ No ❑ Yes – status_____ Report:_____

❑ Dysphagia ❑ Coughing/choking/wet voice when swallowing

❑ History of aspiration ❑ Tracheostomy

❑ Difficulty understanding conversation/reading ❑ Slurred/unclear speech

❑ Abel to communicate needs using speech ❑ Uses a communication device

❑ Voice changes since onset eg soft/hoarse ❑ Laryngectomy

❑ Able to understand spoken language

❑ Mouth condition/Dentition affecting eating eg oral thrush, wet/dry mouth ulcers

❑ Difficulty talking/writing eg incomplete sentence, word difficulties eg distorted

❑ Cognitive difficulty eg memory, impulsivity, planning, organisation, attention

Special Needs

❑ Hearing Impaired ❑ Vision impaired ❑ Literacy

❑ Haemodialysis ❑ IV Therapy ❑ Bariatric ❑ Pressure equipment

❑ Oxygen ❑ Palliative care

❑ Other (braces, splints, prosthesis)_____

❑ Dressings_____

Follow Up Tests/Appointments

Date	Time	Test/Appointment	Location

Long-term Plan (✓ if applicable)

ACAS referral sent: ❑ Yes ❑ No

ACAS in progress: ❑ Yes ❑ No

ACAS complete: ❑ Yes ❑ No

❑ Yet to be determined

❑ Home independently / services / carer

❑ Respite care

❑ Hospice

❑ Supported residential service

❑ Transitional care program – home based

❑ Residential care

❑ Transitional care program - residential

Other

❑ Enduring power of attorney / administrator / guardianship / substitute decision maker

❑ No ❑ Required ❑ Pending ❑ Yes

Name and contact details:_____

_____

End of life plan/Advance care plan complete? ❑ Yes ❑ No

Attached: ❑ Yes ❑ No

IMPORTANT: Please attach copies of medication chart and results of recent pathology / radiology reports & signed patient consent.

Name of person completing this form:_____ Tel No:_____

Signature:_____ Date:_____

THANK YOU

Contact Occasions

Date/Time	Details	By Whom

GIPPSLAND SOUTHERN
Health Service

Leongatha campus
Phone 56675546
Fax 56675626

Korumburra campus
Phone 56542753
Fax no 56542769

(Place Patient Label Here)

Unit Record No _____
Surname _____
Given Name _____
Address _____
Phone _____
D.O.B _____ Sex _____

Patient information re MAINTENANCE CARE at Gippsland Southern Health service

Dear Sir/madam,

Your current clinicians have recommended that you continue your care under our "maintenance program"

This program aims to prevent deconditioning whilst you wait for any of the following:

- Build up confidence to return home with or without home services.
- Await an Aged Care Assessment
- Await an Aged Care Placement
- Your clinical condition although stable prevents you from commencing a GEM/ Rehabilitation program eg post surgery and waiting for bone healing before starting an intensive rehabilitation program.

The program aim to promote Activities of Daily Living (ADL'S), so it is expected that you will dress every day and participate in activities that represent ADL's.

Please note this is **not** a rehabilitation program but initially you will be assessed by Allied Health Professionals who will set up a plan in conjunction with yourself and significant others such as family & care staff.
With your consent and cooperation care staff will implement the plan daily with only intermittent follow up with allied health staff.

If your doctor is from Leongatha or Korumburra it is appropriate that they continue your care at the relevant campus.

In order for you to come on the program you must be in good health with no acute issues such as an infection (clinically stable) so please be sure there are no issues that still need to be dealt with by your current doctor.
There will need to be a handover from your current doctor to the receiving doctor and he must be satisfied of your level of medical stability before you can be admitted.
If you have any follow up appointments at another facility that you are able to arrange transport to attend post admission. The other option is that the appointment can be conducted over teleconference or E- Health. This will reduce costs and inconvenience to all parties involved.

If you have any questions please call any of the above numbers and ask for the nurse in charge.
We ask that you sign this document to ensure your understanding of the program and ask your current ward staff to fax back.

Signature_____Print name & date_____

Thank You