Well Health Care Referral form

Please provide as much information as possible to assist with the referral process and send to

referral@wellhealthcare.com.au

Client Details			
Given name		Family name	
Date of Birth		Gender	
Address			
Home Number		Mobile Number	
Living alone	Yes ☐ No ☐	If No More information	
Interpreter required:	Yes ☐ No ☐	Language spoken at home:	
Allergies:			
Diagnosis and other Relevant medical history:			
Next of Kin / Primary Carer Contact Detail			
Full Name		Mobile number	
Email		Relationship	
Address (if different to client's)			

GP Details			
Clinic Name:		GP Name:	
Clinic Address:		Email:	
Phone：		Fax:	

Funding Methods				
HCP	☐ Yes	☐ No	HCP Level	
Care Plan attached	☐ Yes	☐ No	☐ 1 ☐ 2 ☐ 3 ☐4	
NDIS/ HCP No (if known)			Plan Starting Date	
Copy of NDIS Plan Provided	☐ Yes	☐ No	NDIS Plan Review date	
Self-Manage ☐	NDIA ☐		Plan Manage ☐	
Plan Manager/Case Manager details				

Relevant Information	
Reason for Referral	
Type of residence	☐ House ☐ Apartment/Flat ☐ Aged Care Facility ☐ SRS
Property	Will there be anyone else at the residence? Yes ☐ No ☐ If yes, please specify:
	Any issues to access to home? Yes ☐ No ☐
	Are there any animals present? Yes ☐ No ☐ If yes, please confirm if there are any safety concerns:
	Are there any safety concerns present for OH&S? Yes ☐ No ☐ If yes, please specify:

WELL HEALTH CARE

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Client	Cognitive status:
	Continence:
	Mobility: Any aids to be used (eg; wheelchair, standing machine, HOIST, etc) Yes ☐ No ☐
Other Issues / Risks	☐Behavioral Issues/Aggression ☐ Alcohol/Drug Abuse ☐ Cognitive Issues
	Other: (Please specify)

Nursing services

Request Services			
	Nursing Assessment ☐	General Nursing Management ☐	Wound Management ☐
	Medication Management ☐	Diabetes Management ☐	Urinary Catheter Management ☐
	Palliative Nursing Care ☐	Bowel Management ☐	Stoma Care ☐
	External Feeding Management ☐	Personal Care ☐	
	Other (please specify):		
	Home assistance:		
	Home Cleaning ☐	Gardening ☐	Cooking☐
	Shopping☐	Home modification☐	Social Support☐
	Transportation ☐		
	Others (please specify):		

Referral Details			
Referrer Name:		Organisation	
Phone		Fax	
Email:		Relationship / Title	

Current / pervious provider details (if applicable)			
Provider name:		Contact number:	
Email:		Other:	
Reason of Changing Provider			

For Office use only			
Initial phone call		Initial visit Date	
Initial phone screening	COVID symptoms, Pets (please refer to risk assessment)		
Notes			

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