



REFERRAL - MATER AT HOME

Unit Record No.

Surname

Given Names

DOB

Sex

AFFIX PATIENT IDENTIFICATION LABEL HERE

Please fax completed referral to 07 3163 1767 or email to materathome@mater.org.au

Client Details

Form with fields: Given name(s), Surname, Date of birth, Sex, Address, Contact number(s), Interpreter required?, Country of birth, Email address, Is the patient of Aboriginal or Torres Strait Islander origin?

Safety Alert

Form with checkboxes: Potential staff risk, Animals on property, Infection control, Known allergies

Alternate Contact/Next of Kin/Carer Details

Form with fields: Given name(s), Surname, Relationship to client, Email address, Home phone, Mobile phone, Please contact, Resides with client?

Funding Details

Form with checkboxes: Private, CHSP, WorkCover, Post Acute Care, Residential Aged Care, NIIS, Rehab at Home, Home Care Package, NDIS, Palliative Care, Other

Presenting Condition (including relevant medical history) and Reason for Referral/Goals of Treatment

Large empty text area for presenting condition and reason for referral.

Form with fields: Ward, Hospital, Admission date, Discharge date

Profession Requested

Form with checkboxes: Dietetics, Nursing, Occupational Therapy, Physiotherapy, Psychology, Social Work, Speech Pathology, Exercise Physiology

GP Details

Form with fields: GP name, Practice name, Address, Contact number

Referrer Details (Please call 07 3163 1760 if you have any queries)

Form with fields: Name, Profession, Organisation, Contact number, Fax/email address, Signature, Date, Feedback required, Preferred method of contact



Binding margin - do not write. Do not reproduce by photocopying. All clinical form creation and amendments must be conducted through Health Records.

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NDIS ONLY to complete

NDIS number:

Plan start date:

Plan end date:

- NDIS Portal** **Plan managed** **Self-managed**

If plan or self-managed please complete below:

Name of organisation or individual responsible for account:

Contact number:

Email address:

Please select which discipline(s) you would like to refer to and therapeutic input requested

Occupational Therapy

- Functional capacity assessment
- Assistance with Activities of Daily Living (e.g. showering, dressing)
- Home modifications (e.g. rails, ramps)
Please specify:
- Equipment prescription
Please specify:
- Supported independent living (SIL) assessment
- Specialist disability accommodation (SDA) assessment

Physiotherapy

- Strength and reconditioning
- Hydrotherapy
- Neurological rehabilitation (e.g. stroke, spinal cord injury, Parkinson's disease)
- Carer program and training
- Equipment prescription
- Wheeled walker
- Other (*specify*):

Speech Pathology

- Feeding and swallowing
- Education on feeding management
- Meal time management plans
- Improve communication
- Assistive communication equipment

Social Work

- Counselling/managing impacts of caring
- Mindfulness
- Financial administration and guardianship for clients with cognitive impairment
- Future planning – power of attorney/statement of choices/advanced health directive

Dietetics

- Weight management
- Tube feeding management
- Meal planning
- Malnutrition

Psychology

- Psychological therapy – please provide relevant history and symptoms:

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