South Gippsland **Hospital**

MR/CR562

Community Care Referral Form

Surname:	
Given Name:	
Date of Birth:	Gender:
Phone:	
UR No.:	

Phone: 03 5683 9780 Fax: 03 5683 9746 Email: sghintake@sghs.com.au

Please Note: For the following services, if a client is **over 65 years**, they will need a **My Aged Care (MAC) referral.**

Please submit referral through MAC
https://www.myagedcare.gov.au/make-a-referral or **PH: 1800 200 422**

Do not fill out this form, the MAC referral will come to South Gippsland Hospital

- Day Respite Service
- Diabetes Education
- District Nursing
- Social Support Group
- Falls & Balance Group
- Foot Clinic
- Exercise Physiology (inc. Moovers)
- Home Care Package
- Occupational Therapy
- Physiotherapy

PLEASE COMPLETE ALL SECTIONS

☐ Inpatient (is person in hospital?)	☐ McGrath Breast Care Nurse	☐ Social Work
☐ Diabetes Education (<65 or TCA)	☐ Occupational Therapy (<65)	☐ Counselling
☐ Dietetics (<65 or TCA)	☐ Physiotherapy (<65)	☐ Stomal Therapy (<65)
☐ District Nursing (<65, including wound clinic)	☐ Positive Ageing Service	☐ Transition Care Program
	☐ Sexual Reproductive Health Services	☐ Youth Assist Clinic

PRIORITY OF REFERRAL

☐ **LOW** (Within 14 days) ☐ **MEDIUM** (Within 7 days) ☐ **HIGH** (Within 3 days)

RISKS IDENTIFIED

(e.g., falls, allergies, challenging behaviour, family violence, safety issues, cognitive impairment, other needs)

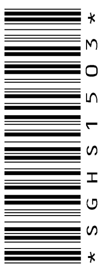
☐ **NONE** ☐ **LOW** ☐ **MEDIUM** ☐ **HIGH**

Additional Information:

REASON FOR REFERRAL & RELEVANT TO CLINCAL INFORMATION

(Attach health summary, current medication list and relevant reports)

Additional Information:



SGHS1503

REFERRER CONTACT DETAILS

Name:	Phone:	Fax/Email:
Signature:		Date:

Office Use Only:

Name:	Signature:	Designation:
OUTCOME: ☐ Accepted	☐ Declined	Date:

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COMMUNITY CARE REFERRAL FORM

MRCR562