Merri Health - Allied Health and Nursing Referral Form

Please ensure all fields on the form are completed for the referral to proceed. Once completed please email to: AlliedHealthFFS@merrihealth.org.au (please password protect)

Client Details:		**Referrer Details:**
Name: ☐Male ☐ Female		Referral Date:
Address:		Name:
		Company:
DOB:		Position:
Phone:	Mobile:	Phone:
Contact for appointments:		Email **(required for invoicing)**:
Country of birth: Is an interpreter required? ☐ Yes ☐ No		Pre Home Visit Risk Assessment attached ☐ Yes ☐ No (If no please identify any risks known in OTHER INFORMATION)
Next of Kin:		**GP Details:**
Name:		Name:
Relationship to Client:		Address:
Phone:		Phone:

Funding Source:

☐ Home Care Package Level: 1 ☐ 2 ☐ 3 ☐ 4 ☐ Comments:
☐ DVA ☐ Gold ☐ White DVA No: _____

Are there any funding limits that Merri health need to be aware of? NO ☐ YES ☐ Amount: _____

Client's medical history	
Services involved	PCA ☐ Cleaning ☐ Respite ☐ Gardening ☐ Shopping ☐ Other:

Please indicate services required: *(please tick)*

☐ **Occupational Therapy** ☐ Home assessment & modifications ☐ Equipment Prescription ☐ Falls Prevention ☐ Dementia support ☐ Activities of Daily Living assessment Client Goals:	**OTHER INFORMATION**
☐ **Physiotherapy** ☐ Falls and Balance assessment ☐ Mobility assessment ☐ Mobility aid prescription ☐ Pain Management Client Goals:	
☐ **Exercise Physiology** ☐ Exercise Program ☐ Education ☐ Lifestyle advice ☐ Assessment for exercise group Client Goals:	
☐ **Speech Pathology** ☐ Swallowing assessment ☐ Communication assessment Client Goals:	
☐ **Dietetics** ☐ Nutritional assessment ☐ Dietary support Client Goals:	
☐ **Podiatry** ☐ Foot care assessment ☐ Nail and skin care ☐ Wound management ☐ footwear advice Client Goals:	
☐ **Nursing** ☐ Clinical Nursing general assessment (Minimum 4 hours) ☐ Assessment for Dementia Supplement (Minimum 2 hours) ☐ Continence Assessment (Minimum 3 hours) Client Goals:	