Homecare Program external REFERRAL FORM

The Royal Children's Hospital Melbourne

Patient Details:

Referral date: **MRN:** **D.O.B**

Given Name: **Surname:**

Address:

Suburb: **Post Code:**

Telephone: **E-mail:**

Referrer Details:

Given Name: **Surname:**

Position Title: **Telephone:**

Hospital / Community service:

Department: **E-mail:**

Parent/Guardian Details:

Given Name: **Surname:**

Relationship: **Telephone:**

Main Consultant/ GP Details:

Given Name: **Surname:**

Hospital:

Telephone:

Child's diagnosis/past medical history:

Nursing Training (Select from the below)

Seizure Management: ☐ Yes

Emergency Medication: ☐ Yes

VP Shunt: ☐ Yes

Tracheostomy care: ☐ Yes

Ventilation Support: ☐ Yes

Oxygen Therapy: ☐ Yes

Asthma Management: ☐ Yes

Oral/Nasal Suctioning: ☐ Yes

Pulse Oximetry: ☐ Yes

Naso-pharyngeal airway: ☐ Yes

Baclofen pump: ☐ Yes

PEG/NGT: ☐ Yes

NGT/NJT: ☐ Yes

Catheterisation: ☐ Yes

Ostomy: ☐ Yes

Other:

Is there an Advanced Care Plan in place? ☐ Yes

Is there an Behaviour Management Plan in place? ☐ Yes

Allergies:

Allied Health Training (Select from the below)

Chest Physio: ☐ Yes

Cough Assist: ☐ Yes

Hoist / Manual Handing: ☐ Yes

Social Situation

Cultural Considerations:

Family circumstances/ psychosocial:

Interpreter required?

☐ Yes

☐ Language

Funding source:

☐ NDIS ☐ ISP

☐ Palliative care ☐ Self funded

☐ Other

How many support workers for training?

Support workers name/s:

Support workers agency name:

Telephone:

Consent obtained for referral? ☐ Yes ☐ No

Parent/guardian consenting to the referral: