ST VINCENT'S HOSPITAL MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

St. Vincent's Health Independence Program Referral Form

UR/Bradma label

Refer to HIP Central for the following HIP Services:

Referral Date:

- ☐ Cardiopulmonary Rehabilitation (attach the following)
  - ○ TTE / TOE results (Cardiac and Heart Failure Rehab)
  - ○ RFT and CT Chest (Pulmonary Rehab)
  - ○ Home Oxygen ○ YES ○ NO
  - ○ Advanced Care Plan ○ YES ○ NO
- ☐ Community Rehabilitation Services (centre-based and home-based)
- ☐ Complex Care Services (formerly HARP)
- ☐ Continence Clinic
- ☐ Falls and Balance Clinic **(multidisciplinary assessment clinic)**
- ☐ Cognitive Dementia and Memory Service (CDAMS)
- ☐ Geriatric Medical Specialist Clinic (GMC)
  - ○ Medical referral required

We require the following information – please attach with this form:

- ☐ Medical, surgical, allied health discharge summaries
- ☐ Procedure report
- ☐ Medication list
- ☐ Discipline handover *(if applicable)*
- ☐ GP Health summary *(if applicable)*

Tel: 1300 131 470 Fax: (03) 9231 2202 Email: hipcentralreferrals@svha.org.au

*****We require minimum dataset to process all referrals. Please complete all fields *****

Client Name:	DOB:	Indigenous Status:
Sex assigned at birth:	Gender Identity:	Pronouns:
Address:	Preferred method for communication: Phone / SMS / Email (please include)	
Tel:	Does client consent to referral? ○ YES ○ NO	Contact person for this referral (*details*):
Country of Birth:	Marital status:	Interpreter required: ○ YES ○ NO Language:
Medicare number:	Pension number:	DVA: ○ YES ○ NO
Next of Kin:	Relationship to client:	Contact number:
GP Name:	GP Address:	
Contact number:	Fax:	

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Relevant Medical / Surgical History: (diagnosis, onset date, recent investigations) *Attach patient health summary. Limit your response to 130 words.*

Reason for referral (include patient goals) *Limit your response to 130 words. Attach further information if required.*

Intervention required: ☐ **PT** ☐ **OT** ☐ **SP** ☐ **DIET** ☐ **SW** ☐ **Care Coordination**
Other:

If home based therapy requested, reason why?

Current Functional Status: (Please tick and add detail for each below)

Cognition: ☐ Normal ☐ Minor Changes ☐ Confusion ☐ Other

Duration (if anything other than normal): ☐ less than 3/12 ☐ more than 3/12

Continence: ☐ Continent ☐ Incontinent ☐ Bladder ☐ Bowel ☐ Continence Aids

Communication: ☐ Normal ☐ Impaired

Mobility: ☐ Independent ☐ Assisted ☐ Unable ☐ Without Aid ☐ With Aid

Environmental Issues: OT Home Assessment Completed ◯ YES (attach report) ◯ NO

Are other Services involved in client care:

☐ Post-Acute Care	☐ Community Nursing	
☐ Support at Home Package level:	☐ Case Manager: ◯ YES ◯ NO	Case Manager Name / Contact details:
☐ NDIS *Contact details*:	☐ Other *(details)*:	

Referrer name:	Position/discipline:
Contact number:	Fax:
Email:	