

 ST VINCENT'S HOSPITAL MELBOURNE	St. Vincent's Health Independence Program Referral Form	UR/Bradma label
<u>Refer to <i>HIP Central</i> for the following HIP Services</u> <ul style="list-style-type: none"> <input type="checkbox"/> Cardiopulmonary Rehabilitation <input type="checkbox"/> Cardiac Rehabilitation <input type="checkbox"/> Community Rehabilitation Services <ul style="list-style-type: none"> ○ Oncology Rehabilitation Group ○ Movement Disorders (Parkinson's) Group ○ Back to Life Group (back pain) <input type="checkbox"/> Complex Care Services (formerly HARP) <input type="checkbox"/> Continence Clinic <input type="checkbox"/> Falls and Balance Clinic <input type="checkbox"/> Rehabilitation in the Home (RITH) <input type="checkbox"/> Cognitive Dementia and Memory Service (CDAMS) <input type="checkbox"/> Geriatric Medical Specialist Clinic (Medical referral required) 		<u>Refer <i>direct</i> for the following HIP Services</u> Please call to discuss referral as required. <ul style="list-style-type: none"> <input type="checkbox"/> Barbara Walker Centre for Pain Management (Medical referral required) Tel: (03) 9231 4681 Fax: (03) 9231 4660 Email: BWCPM@svha.org.au <input type="checkbox"/> Polio Services Victoria Tel: (03) 9231 3900 Fax: (03) 9231 3808 <input type="checkbox"/> Young Adults Complex Disability Clinic Tel: (03) 9231 4672 Fax: (03) 9231 3808
Client Name:		Referral Date:
DOB:	Sex:	Marital status:
Address:		
Tel:		Mobile:
Country of Birth:		Interpreter required: Yes/No Language:
Medicare number:	Pension number:	DVA Gold Card:
Next of Kin:		
Relationship to client:		Contact number:
Referrer name and position:		
Contact number:		Fax:
Email:		
GP Name and Address:		
Contact number:		Fax:

****Please attach / forward all relevant discipline handovers at time of discharge****

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



**ST VINCENT'S
HOSPITAL**
MELBOURNE

**St. Vincent's
Health Independence
Program
Referral Form**

UR/Bradma label

Relevant Medical/Surgical History: (diagnosis, onset date, recent investigations)

Past Medical history:

Aims of intervention:

Intervention required : PT OT SP DIET SW Podiatry Care Coordination
Other:

If home based therapy requested, reason why?

Current Medication and Dosage:

Current Functional Status: (circle)

Cognition: Normal Minor Changes Confusion Other

(Detail)

Continence: Continent Incontinent Bladder - Bowel Independent with Aids

(Detail)

Communication: Normal Impaired

(Detail)

Mobility: Independent Assisted Unable Without Aid With Aid type

(Detail)

Self-Care: Independent Assisted

(Detail)

Social Issues:

(Detail)

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

(Detail)

Are other Services Involved in Care? :

☐ ACAS

☐ Post-Acute Care

☐ Respite

☐ Package: Level 1-2 Level 3-4 NDIS

☐ Other

☐ Community Services

☐ Mental Health Service/APAT

☐ Community Nursing

☐ Commonwealth Home Support Program (CHSP)

Case Manager : YES / NO Contact details:

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