

My Care Partners Referral Form

Please send this referral to our service provider clinicians at EACH via your MD Exchange function. EDI address: eachpatt

DATE OF REFERRAL	<<Miscellaneous:Date>>
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URGENCY
Urgency: **intake use only
REFERRAL DETAILS
Reason for referral and issues to be addressed: (eg: Reduce falls risk, improve medication management, uncontrolled diabetes / other chronic condition, assist navigation of multiple health providers, improve wellbeing, assist transport options): <<Reason eg: Reduce falls risk, uncontrolled diabetes>>
Acute health deteriorations/changes: <<Acute health deteriorations/changes eg: recent fall>>
Patient self-reported goals: (eg: Engage services, transport, reduce falls, improve independence, pain management, reduce CVD risk, prevent complications of diabetes) <<Patient self-reported goals eg: engage services >>
Services engaged: (eg: domestic assistance x times per week, personal cares, support worker, carer, meals on wheels, DVA, workers compensation, community transport) <<Services engaged>>
Is patient in receipt of Home Care Package? <<Is patient in receipt of Home Care Package?>>
Falls risk: <<Falls risk>>
Falls history: <<Falls history>>
Mobilises with: <<Mobilises with>>

REFERRER DETAILS	
Referring practice: <<Practice/Location:Name>>	Referring practice address: <<Practice/Location:Address>>
Practice phone: <<Practice/Location:Phone>>	Practice email: <<Practice/Location:E-mail>>
Doctor's name: <<Doctor:Name>>	Doctor's phone: <<Doctor:Phone>>

Email: <<Doctor:E-mail>>

PATIENT DETAILS

Family name: <<Patient Demographics:Surname>>

Given Names: <<Patient Demographics:First Name>> <<Patient Demographics:Middle Name>>

Sex: <<Patient Demographics:Gender>>

Date of Birth: <<Patient Demographics:DOB>>

Age: <<Patient Demographics:Age>>

MRN: <<Patient Demographics:Record Number>>

Address: <<Patient Demographics:Full Address>>

Phone (H): <<Patient Demographics:Phone (Home)>>

Phone (M): <<Patient Demographics:Phone (Mobile)>>

Phone (W): <<Patient Demographics:Phone (Work)>>

Email: <<Patient Demographics:E-mail>>

Aboriginal and Torres Strait Islander Status: <<Patient Demographics:ATSI>>

Ethnicity: <<Patient Demographics:Ethnicity>>

Interpreter Required: <<Interpreter required>>

If yes to above, language spoken: <<Patient Demographics:Language Spoken>>

Has the patient opted out of My Health Record (has not opted out)? <<Pt has My Health Record (has not opted out)>>

Medicare card no: <<Patient Demographics:Medicare Number>>

Expiry (mm/yy): <<Patient Demographics:Medicare Expiry Date>>

NOTE: Pt must have Medicare to be eligible for MCP

DVA Card Number: <<Patient Demographics:DVA Number>>

NOTE: If DVA Card Holder, refer to DVA unless Hospital Avoidance category of client.

Pension No: <<Patient Demographics:Pension Number>>

Health Care Card No (if applicable): <<Health Care Number >>

Private health fund: <<Patient Demographics:Health Insurance>>

Private health fund No: <PtInsNo>

NDIS Participant: <<NDIS>>

My Aged Care Participant: <<My Aged Care Participant>>

Marital Status: <<Patient Demographics:Marital Status>>

Occupation: <<Patient Demographics:Occupation>>

Current GP Management Plan in place: <<GPMP in place>> Ensure GPMP/TCA is saved to clinical software with naming convention (MyCP) and original date	Date last updated: <<GPMP date updated>>
Current Team Care arrangement in place: <<TCA in place>>	Date last updated: <<Date of TCA>>

ELIGIBILITY
Complete yes/no as applies to the patient:
1. <Is the patient at risk of hospitalisation in the next 12 months?> <<Is the pt at risk of hospitalisation in the next 12 mnth>>
2. <Is the patient living with a complex or chronic illness with complex/unmet needs?> <<Is pt living with illness with complex/unmet needs>>
3. <Does the patient require coordination of their care?> <<Does the pt require coordination of their care>>
4. <Is the patient committed to actively participating in the program for the duration of 12 months?> <<Is pt committed to actively participate in program>>
5. Is the patient available to engage for the entire 3-month intervention period? <<Is patient available to engage for 3-month period>>
6. The patient is NOT eligible if they are younger than 17, a mental health condition is their sole diagnosis, they live in a RACF, they live outside of South Western Sydney, they are receiving palliative care, they are receiving renal dialysis, they are currently pregnant, please tick OK. <<Have checked all exclusion criteria for the patient>>

MEDICAL HISTORY
Smoking status: <<Smoking status>> <<Clinical Details:Smoking Quitting Stage>>
Alcohol history: <<Alcohol history>><<Clinical Details:Alcohol>>
Patient Medical History - including chronic conditions: <<Clinical Details:History List>>
List all current medications: <<Clinical Details:Medication List>>

NEXT OF KIN/CARER	
Name: <<Patient Demographics:Next of	Relationship to patient: <<Patient

Kin>>	Demographics:Next of Kin Relationship>>
Phone: <<Patient Demographics:Next of Kin Phone>>	NOK address: <<Patient Demographics:Next of Kin Address>>
Power of Attorney or Guardian appointed: <<Power of Attorney or Guardian appointed>>	
If yes, please provide details: <<provide details of guardian or power of attorney>>	
Contact: <<Contact client or NOK?>>	
Risk of carer burnout/stress: <<Risk of carer burnout or stress>>	

SOCIAL HISTORY

Please indicate which of the following social and environmental risk factors are present.

Social hx: <<Clinical Details:Social History>>

Cognitive impairment/decline:
<<Cognitive impairment or decline>>

Lives alone without support/isolation:
<<Social isolation>>

Evidence of financial strain:
<<Financial strain>>

Unstable living environment/issues with housing:
<<Unstable living conditions>>

Concerns of elder abuse/domestic abuse:
<<Concerns of abuse?>>

Squalor/self-neglect: <<Squalor/self neglect>>

Issues with access/transport difficulties:
<<Issues with transport>>

DVA details: <<If DVA card holder, does patient utilise services>>

PATIENT CONSENTS - please also record consent in the clinical notes

MCP Patient Information Booklet provided to the patient. Patient is aware they will be called from a hospital number (shows as unknown number)	<<MCP Patient Information Booklet provided>>
My Care Partners program consent	<<My Care Partners program consent>>
My Care Partners comprehensive assessment consent	<<MCP comprehensive assessment consent>>
My Care Partners information sharing consent	<<MCP information sharing consent>>
My Care Partners evaluation consent	<<My Care Partners evaluation consent >>