Referral to Bolton Clarke
Home and Community Support

Referrer: Please complete this form and fax it to Bolton Clarke as follows:
Melbourne: 1300 657 265; **Other Vic** (03) 5225 5799; **NSW** (02) 6584 5940;
QLD & Nth NSW: 1300 792 129; **SA & WA**: 1300 768 296

This form is available from the 'Referrers' area in boltonclarke.com.au/referrals/**Phone**: 1300 22 11 22

Client details: (Attach adhesive label if appropriate)

Name: (Given name) (Family name)

Bolton Clarke UR: (if known)

Address:

Phone:

Date of birth:

Gender:

Next of kin/contact:

Phone:

Interpreter required: ☐ No ☐ Yes Language spoken at home:

Diagnoses:

Relevant past history:

Allergies:

Pension/DVA number: (if applicable)

Client is aware of referral ☐ Yes ☐ No

GP details if not referrer

Name:

Phone:

Address:

Fax:

Name:

UR:

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Referrer details:

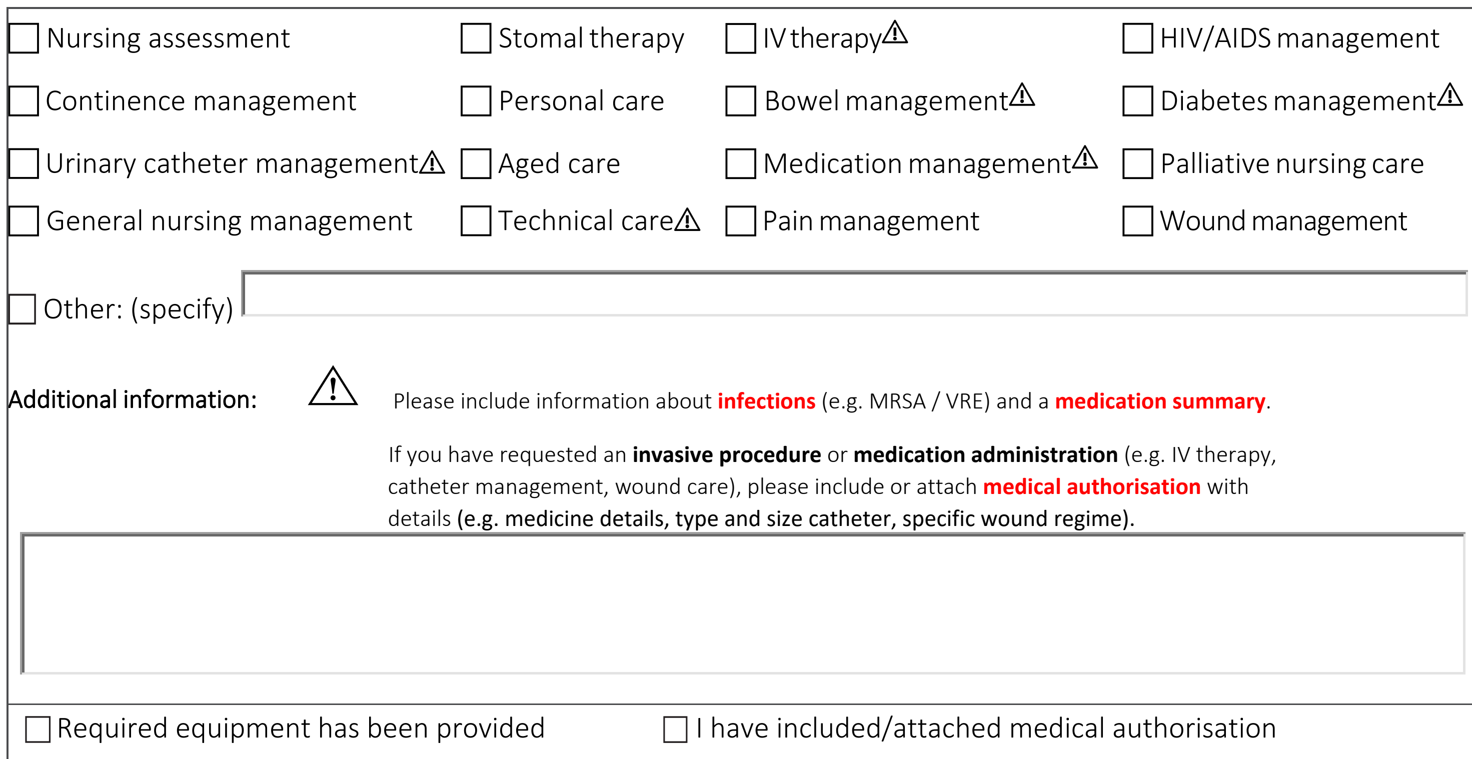
(Complete as applicable)

Organisation/network: (e.g. Peninsula Health)	The information has been faxed/phoned ☐ Yes ☐ No
Hospital/facility:	Ward/clinic:
Referrer name:	Phone:
Email:	Fax:
Planned discharge date:	Requested first visit date:
GP/hospital DVA provider no.: (NOT client's VX number)	ABN:

Days you usually visit the client (Community referrers):

Nursing care requested:

(see below for home assistance) (Tick as many as required)



☐ Nursing assessment	☐ Stomal therapy	☐ IV therapy⚠	☐ HIV/AIDS management
☐ Continence management	☐ Personal care	☐ Bowel management⚠	☐ Diabetes management⚠
☐ Urinary catheter management⚠	☐ Aged care	☐ Medication management⚠	☐ Palliative nursing care
☐ General nursing management	☐ Technical care⚠	☐ Pain management	☐ Wound management

☐ Other: (specify)

Additional information: ⚠ Please include information about **infections** (e.g. MRSA / VRE) and a **medication summary**.

If you have requested an **invasive procedure** or **medication administration** (e.g. IV therapy, catheter management, wound care), please include or attach **medical authorisation** with details (e.g. medicine details, type and size catheter, specific wound regime).

☐ Required equipment has been provided ☐ I have included/attached medical authorisation

Home assistance:

(Tick as many as required)

☐ Domestic assistance	☐ Transport	☐ Social support	☐ Respite
☐ Shopping	☐ Personal care	☐ Other: (specify)	

Name: ______ UR: ______

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Relevant information:

On chemotherapy: ☐ No ☐ Yes – details:
Cognitive status:
Continence:
Mobility: (Bolton Clarke staff will not be able to use the hoist unless it was serviced in the past 12 months.)
Hoist to be used by BC: ☐ No ☐ Yes If yes, date of last service:
Client safety issues:
Carer:
At risk:
Access to home:
Other:

Other services involved or referred to:

Home Care Package: Organisation: Package level:
Case Manager: Name: Phone:
Community services ☐ Domestic assistance ☐ Respite ☐ Personal Care ☐ Home maintenance ☐ Other
Allied health: (specify)
ACAS/ACAT: (specify)
My Aged Care: Referred ☐ No ☐ Yes RAS assessment: ☐ No ☐ Yes MAC ID: if known
Transitional Care Prog:
Other:

Bolton Clarke is the brand name for a group of companies being RSL Care RDNS Limited ABN 90 010 488 454, Royal District Nursing Service Limited ABN 49 052 188 717 and RDNS HomeCare Limited ABN 13 152 438 152.