Australian Government
Department of Social Services

myagedcare

Please do not write in this space
FOR PATIENT IDENTIFICATION
LABEL ONLY

My Aged Care Hospital Referral Request
(South Australia)

Select all that apply:

FAX Recipient
- ☐ My Aged Care
- ☐ Local ACAT

Hospital Location
- ☐ Metro
- ☐ Country

For use of this form, please see accompanying 'Instructions for Use'. Complete all relevant sections and to ensure correct and timely processing, please fax only one client referral at a time.

My Aged Care Fax: 1800 728 174

Note. This referral does not guarantee access to services. Provision of service will be dependent on service availability in the area and the client's specific needs.

Referrer Details* (* denotes mandatory section)

Name of Referrer:		**Referrer Ph:**	
Referrer Email:			
Hospital Name:			
Date of Referral:	_____/_____/_____	**No. Fax Pages:**	(including this one)

Client Details*

Family Name:		**Given Name:**	
Gender:		**DOB (dd/mm/yyyy):**	_____/_____/_____
Home Address:			
Client Ph (Home):		**Client Ph (Mobile):**	
Medicare Card #:	☐☐☐☐-☐☐☐☐☐-☐ Ref no. ☐	**DVA Card #:** **Colour:**	_____ ☐ Gold ☐ White ☐ Orange
Indigenous Status:	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown		
Interpreter Required:	☐ Yes ☐ No	**Specify Language:**	

Current Hospital Location:	Address:			
	Ward Name / #:		Ward Ph:	
	Admitted Date:	_____/_____/_____	Discharge Date (expected):	_____/_____/_____
Discharge Location (if not home):	Details:	☐ Respite ☐ Relatives Other _____		
	Address:			
	Phone:			

Consent For Referral* This section must be completed for the referral to be actioned

Has consent been provided for this referral?	☐ Yes ☐ No

If not client, consent provided by:		Ph:	
Relationship to the Client:			
Reason if not the Client:			

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Client Name:_____

Additional Client Information

Usual Living Arrangements	☐ Alone ☐ With Family/Partner/Carer ☐ Homeless Other:_____			
Contact 1 Details:	Relationship to the Client:	☐ Partner ☐ Next of Kin ☐ Carer ☐ Guardian Other:_____		
	Name:		Ph:	
	Address:			
Contact 2 Details:	Relationship to the Client:	☐ Partner ☐ Next of Kin ☐ Carer ☐ Guardian Other:_____		
	Name:		Ph:	
	Address:			
GP Details:	Name:		Ph:	
	Practice Name:			

Existing Services Please complete if details of existing services are known

Service	Service provider contact details

Does the client only need to recommence provision of these existing services? If yes, please contact the existing service provider(s) directly	☐ Yes ☐ No

Post-Acute Care Details Please complete if client has also been referred to Post-Acute Care

Has the patient been referred to a post-acute care programme?	☐ Yes ☐ No
What services will be provided?	
How long will this programme provide patient support?	_____ weeks _____ days
Is the patient expected to need services at the end of this programme?	☐ Yes ☐ No

Provider Details (1)	Name:		Ph:	
Provider Details (2)	Name:		Ph:	

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Client Name:_____

Why The Client Is Seeking Services Or Requires An Assessment*

Description of problem or issue as identified by the referrer or the client: (For example relevant medical conditions, reason for admission, mobility, fall risk or cognition issues. The details within this section should demonstrate why the client is unable to live independently in the community without support.)

Request For ACAT Assessment* Please complete if referring client for a comprehensive assessment

Metro SA hospital: Please fax this completed form to your local ACAT
Country SA hospital: Please fax this completed form to My Aged Care 1800 728 174

Patient is medically stable and requires a comprehensive assessment for entry into the following programme:		
Residential Care: ☐ Permanent ☐ Respite	☐ **Transition Care Program**	☐ **Home Care Package**
Location of Assessment	☐ Hospital ☐ At home	
	Other (please specify):	
Is a family member, carer or client advocate required at the assessment?	☐ Yes ☐ No	
	If Yes, name: _____ phone: _____	

Request For CHSP Services* Please complete if referring client for services

Please complete and fax to My Aged Care 1800 728 174

Estimated duration of services:	☐ Short term (< 6 weeks)	☐ Medium term (6 – 12 weeks)	☐ Long term (> 12 weeks)
☐ Community Nursing	☐ Transport	☐ Meals	
☐ Personal Care	☐ Domestic Assistance	☐ Home Modifications	
Allied Health, please specify:			
Other, please specify:			

Does the patient require a Home Support Assessment? conducted by Regional Assessment Service (RAS)	☐ Yes ☐ No
Date Services Required:	
Does the client require CHSP Services to facilitate discharge?	☐ Yes ☐ No
If Yes, which organisation could provide these services?:	

Provider Details (1)	Name:		Ph:	
Provider Details (2)	Name:		Ph:	

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Client Name:_____

Additional Information

Have you attached relevant case information including allied health assessments, wound care details, discharge summaries, care plans or relevant medical summaries? (please do not fax the client file)	☐ Yes ☐ No

Other Comments: