SUMMITCARE
WARMTH WORTH WELLBEING

Health Professional and GP Fax Referral Form

Important:
- Complete all relevant sections. Fax only one patient/client referral at a time and please only send one referral per client/patient.
- Use this form for referring to SummitCare for access to Residential Care or Residential Respite.
- Please consider using the online form for faster and more efficient outcomes for your patients/clients. Confirmation of receipt will also be provided when using the online form.

Email the completed form to SummitCare: referral@summitcare.com.au
Note. This referral does not guarantee access to services. Provision of services will be dependent on service availability in the area and the client's specific needs.

Referrer Details			
Name of Referrer:		Referrer Phone:	
Organisation Name:		Referrer Role:	
Organisation Address:			

Patient/Client Details			
First Name:		Last Name:	
Gender:		DOB *(dd/mm/yyyy):*	
Home Address:			
Can the patient be contacted by phone?	☐ Yes ☐ No	Patient Phone Number:	
Medicare Card#: (including IRN):		DVA Card Number:	
		DVA Card Colour:	☐ Gold ☐ White ☐ Orange
Is your patient of Aboriginal or Torres Strait Islander origin?:	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown		
Interpreter Required?	☐ Yes ☐ No	Specify Language:	

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Consent For Referral* This section must be completed for the referral to be actioned Consent to make this referral also includes consent from the patient /client to have their personal information stored within My Aged Care, and for it to be provided to relevant assessment organisations, service providers and health professionals, and consent to share information back with you (the referrer) about the referral.			
Has consent been provided for this referal?	☐ Yes	☐ No	

If not patient, consent provided by:		Phone Number:	
Relationship to the patient:			
Reason if not the patient:			

Additional Patient/Client Information				
Does the patient have a carer/support person?	☐ Yes	☐ No		
Usual living arrangements:				
Details of Carer/ Support person 1:	Relationship to the patient:			
	Name:		Phone:	
	Home Address:			
Do they need to be present at any Aged Care Assessments?	☐ Yes	☐ No		

Details of Carer/ Support person 2:	Relationship to the patient:			
	Name:		Phone:	
	Home Address:			
Do they need to be present at any Aged Care Assessments?	☐ Yes	☐ No		

GP Details:	Name:		Phone:	
	Practice Name:			

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Why the Patient/Client Is Seeking Services Or Requires an Assessment*

Description of problem or issue as identified by the referrer or patient, for example relevant medical conditions, reason for admission, mobility, fall risk or cognition issues.

Patient/Client Concerns* Are there concerns with any of the following? Please select all that apply.

- ☐ Health concerns impacting independence
- ☐ Recent falls
- ☐ Pain
- ☐ Weight loss or nutritional concerns
- ☐ Feeling lonely, down or socially isolated
- ☐ Memory loss or confusion
- ☐ Risks, hazards or safety concerns in their home
- ☐ Special needs

Patient/Client Function* Based on your knowledge is the patient/client able to:

	Without help	With a little help	With a lot of help	Completely unable	Not known
Get out of bed or chairs easily?	☐	☐	☐	☐	☐

	Without help	With some help	Completely unable	Not known
Eat their meals?	☐	☐	☐	☐
Go to the toilet?	☐	☐	☐	☐
Walk easily?	☐	☐	☐	☐
Shower or have a bath?	☐	☐	☐	☐
Manage their own medications?	☐	☐	☐	☐
Travel in the community?	☐	☐	☐	☐
Go shopping for groceries?	☐	☐	☐	☐
Prepare their own meals?	☐	☐	☐	☐
Do housework?	☐	☐	☐	☐
Get Dressed?	☐	☐	☐	☐
Manage their money?	☐	☐	☐	☐

Patient/Client Function: How can you use this information?

If you have answered "without help" for most functions and "some/a little help" for a few functions, the patient may benefit from access to one or more Commonwealth Home Support Programme (CHSP) services. Access to these services would be determined by an assessment undertaken by a Regional Assessment Service (RAS).

If you have answered "with a lot of help" or "completely unable" for a number of functions, the patient may benefit from more extensive support such as a Home Care Package or may benefit from Residential/Respite Care or Short Term Restorative Care. Access to these programs would be determined by an assessment undertaken by an Aged Care Assessment Team (ACAT).

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Recommendation* I want to recommend my patient/client for:			
☐	Comprehensive assessment by an Aged Care Assessment Team (ACAT)	Complete section A	Recommended if your patient has lower levels of function and would benefit from access to a Home Care Package or Residential Care
☐	Home support assessment by the Regional Assessment Service (RAS)	Complete section B	Recommended if your patient has higher levels of function and would benefit from access to CHSP services

Section A: Recommended for ACAT Assessment

To support aged care assessment, please specify the aged care programs your patient would benefit from:

☐ Residential Care ☐ Residential Respite ☐ Home Care Package

☐ Short Term Restorative Care

Location of Assessment:	☐ Usual residence
	Other (please specify):

Section B: Recommended for RAS Assessment (CHSP Services)

To support aged care assessment, please specify the types of services the patient would benefit from:

☐ Community Nursing ☐ Transport ☐ Meals

☐ Personal Care ☐ Domestic Assistance ☐ Home Modifications

Allied Health, please specify:	
Other, please specify:	
Estimated duration of services:	☐ Short term (< 6 weeks) ☐ Medium term (6 – 12 weeks) ☐ Long term (> 12 weeks)
Date Services Required:	

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 patient/client file)	☐ Yes ☐ No

Other Comments: