RESET

Health
South Western Sydney
Local Health District

THIS FORM SHOULD BE COMPLETED ONLINE, THEN PRINTED AND EMAILED DIRECTLY TO: swslhd-triplei@health.nsw.gov.au

COMMUNITY HEALTH NURSING

TRIPLE I (HUB) NURSING REFERRAL FORM
Intake—Information—Intervention

Please check information in Cerner with client to ensure up to date e.g. phone number, NOK, temporary address, etc

Date of Referral to TRIPLE I:	Date Ready for Care:	MRN:

REFERRER DETAILS:

Name (PRINT):	Telephone:	Fax:	Pager no.:
Department / Organisation:			
Client Aware of Referral to Service:	Yes ☐	No ☐	Unknown ☐

CLIENT DETAILS:

Title:	Family Name:	First Name:	Middle Name:
Sex:	Date of Birth:	Estimated Date of Birth: Yes ☐	No ☐
Medicare No:		Expiry Date:	
Health Insurance Fund/DVA:		Membership No:	
Workcover Provider:		Claim No:	

Treatment Address ☐ **Lives alone** ☐ **Lives with others, specify:**

Street:	Suburb:	Postcode:
Telephone:(Home):	(Work):	(Mobile):

Residential Address ☐ **As above**

Street:	Suburb:	Postcode:
Telephone:(Home):	(Work):	(Mobile):

Country of Birth:	Aboriginality:	Preferred Language:
Interpreter Required	Yes ☐	No ☐ Unknown ☐

DOCTOR RESPONSIBLE FOR CARE & REVIEW:

AMBULATORY DOCTOR ☐ MEDICAL SPECIALIST ☐ GENERAL PRACTITIONER ☐

Name:	Pager/ mobile phone:	Next review date:

GP DETAILS:

GP Name:	Telephone:	Fax:

CHECKLIST (Y/N):

MEDICATIONS SENT HOME WITH CLIENT	☐
ORIGINAL COMMUNITY HEALTH MEDICATION CHART SENT HOME WITH CLIENT	☐
COMMUNITY HEALTH AUTHORITY TO PERFORM CLINICAL PROCEDURES SENT WITH CLIENT	☐
ELECTRONIC DISCHARGE SUMMARY COMPLETED IN CERNER	☐
3 DAY SUPPLY OF WOUND CARE EQUIPMENT/ SUPPLIES SENT HOME WITH CLIENT	☐

PERSON TO CONTACT:

Name (PRINT):	Relationship to Client:
Telephone:(Home): (Work): (Mobile): Email address:	
Address:	

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AMR018.003

May 21: Rev 7

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Client Family Name:	First Name:	Date of Birth:	MRN:

Diagnosis /History:

Reason for referral /treatment requested/wound treatment:

Allergies_

Current Services:

Is this a recurrent condition? Yes ☐ No ☐

Is a further medical consult required? (e.g. infectious diseases consult for complicated cellulitis) Yes ☐ No ☐

Details_

OCCUPATIONAL HEALTH & SAFETY (Tick the relevant column):	**YES**	**NO**	**UNKNOWN**
Known Infectious Disease: e.g. Hep A, B or C, TB, etc	☐	☐	☐
Known Multi-resistant Organism: e.g. VRE, MRSA, etc	☐	☐	☐
Cytotoxic Medication (e.g. for Cancer, Arthritis, Psoriasis)	☐	☐	☐
If yes, please specify details:			

RISK ASSESSMENT— MUST BE COMPLETED FOR ALL REFERRALS (Tick the relevant column)	**YES**	**NO**	**UNKNOWN**
Current problems with alcohol and substance misuse	☐	☐	☐
Domestic Violence	☐	☐	☐
Animals of concern at home (if yes, request they be locked up prior to home visit)	☐	☐	☐
Safety issues. Precautions or protocols to be taken during administration of requested medications (if yes, ask for information to be faxed and original given to client.	☐	☐	☐
Behavioural issues (e.g. aggression)	☐	☐	☐
Environmental risks for staff (e.g. building works, weapons, poor access/lighting)	☐	☐	☐

Comments:

Altered parameters for vital signs: Mandatory field please tick yes or N/A and if yes, please populate the altered parameters. Yes ☐ N/A ☐

Respiratory:

BP:

O2 Stats:

Pulse:

For "DIRECT ACCESS COLONOSCOPY REFERRAL", please complete additional section in next page

TRIPLE I HUB Fax number: 4621 8799 Telephone: 1800 455 511 email: SWSLHD-TripleI@health.nsw.gov.au

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Intake—Information—Intervention

POSITIVE FOBT DIRECT ACCESS COLONOSCOPY REFERRAL DETAILS

SPECIALIST DETAILS:

Full Name of Specialist being referred to: _____

MEDICAL HISTORY:

Weight (kg):	Height (m):
Previous colonoscopy: Y / N	If YES - year of last colonoscopy:

Current Medications:

Please tick ALL items:	YES	NO
Cardiac disease (e.g. IHD, heart failure, pacemaker, valve disease, coronary stent)	☐	☐
Chronic respiratory disease (e.g. COAD, poorly controlled asthma)	☐	☐
Chronic kidney disease EGFR < 60 ml/min/1.73m^2	☐	☐
Cirrhosis	☐	☐
Diabetes on insulin	☐	☐
Obstructive sleep apnoea	☐	☐
Advanced malignancy	☐	☐
Impaired mobility affecting independence with bowel preparation (e.g. CVA, Parkinson's)	☐	☐
Previous history of difficult colonoscopy (e.g. incomplete colonoscopy, complication)	☐	☐
Previous history of difficulties with anaesthesia	☐	☐
On anticoagulant (warfarin, apixaban, dabigatran, rivaroxaban)	☐	☐
On antiplatelet other than aspirin (e.g. clopidogrel, prasugrel, ticagrelor, asasantin)	☐	☐
Does patient requires a specialist assessment for GI symptoms prior to colonoscopy?	☐	☐
Is the patient anaemic or iron deficient?	☐	☐

Other issues - Please specify :

Please attach recent blood tests (FBE, UEC, LFT, Iron Studies) and FOBT results with referral

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