AUSNEST UNITY

Your Trusted Companion in Home, Disability & Community Care

Referral form

Please fill and send this form to ***support@ausnestunity.com.au***

1. Referral Type

Referral type — DVA Community Nursing ☐

2. Client Information

Client information

DVA file number

Card type — Gold ☐

White ☐ ▶ Please specify the accepted condition the service relates to

Title — Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Surname

Given name(s)

Date of birth

Address

POSTCODE

Contact number

Specify type of accommodation

Note: If the client is a resident in a Residential Aged Care Facility, they are ineligible to receive Community Nursing services.

☐ Private residence

☐ Independent Living Unit (ILU)

3. Referrer Details

Referrer name:	
Referrer position:	
Referrer organisation:	
Referrer address:	
Contact details:	Phone: Email:

4. Patient GP Details	
Name:	
Practice name:	
Practice address:	
Practice contact details:	Phone: Email:
Specialist's details:	

5. Current Service Providers	
NDIS recipient? Y ☐ N ☐	Provider details:
My Aged Care recipient? Y ☐ N ☐	Provider details: Program details (HCP, CHSP):
Case Manager details:	
Service coordinator details:	

6. Medical/ Surgical history & Current Care Plan: (Brief Description)
Current Medications:

7. Past Medical/ Surgical History:

(Provide summary of the patient's past medical/ surgical history)

8. Allergies:

Please list any drug, food or environmental allergies

9. Reason for Referral:

Clearly state the reason for the referral, emphasising the specific nursing services required, and any unique considerations related to the patient's care.

10. Services Requested:

Provide as much details as possible (Wound care, catheter change, feeding regime etc)

Wound chart attached:	Y ☐	N ☐
Catheter/SPC details (size/gauge, insertion date last change date):	Y ☐	N ☐
Feeding tube details (size/gauge, insertion date last change date):	Y ☐	N ☐

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11. Other health/support services

Is the client currently receiving any other health/support services?

No ☐

Yes ☐ ▶ Specify the services

- ☐ Veterans' Home Care (VHC)
- ☐ Coordinated Veterans' Care (CVC)
- ☐ Allied Health – please specify

  _____

  Other – please specify

  _____

12. Authorisation:

I hereby authorise the release of the above information for the purpose of facilitating the referral to Ausnest Unity PTY LTD.
Referrer Signature:
Full name (Printed):
Date:

13. Patient Consent:

I hereby confirm that the patient, as detailed above, has given consent for this referral, and therefore consents to the use, storage, and sharing of their health information by Ausnest Unity, in line with The Privacy and Personal Information Protection Act 1998 (PPIP Act).
Referrer Signature:
Full name (Printed):
Date:

Address: PO Box 25, Wollongong, New South Wales (NSW) – 2520
M: +61 490 429 697