|  |  |  |  |
| --- | --- | --- | --- |
| Referral to:  Logo, icon  Description automatically generated  Specialising in  Continence  Assessment  DVA Provider No: 9722181T  NDIS Provider No:  4050066722 | **Client Details** | | |
| Surname: **enter text.** Given Names: **enter text.**  Other name if known by a different name: **enter text.** | | |
| Date of Birth: **enter text.** | | |
| Phone Number/s: **enter text.**  Email address: **enter text.** | | |
| **Please give details on the best person to contact if it is not the person being referred and relationship to client (eg. husband, wife, mother, father, friend etc):**  Name of person to contact: **enter text.**  Relationship to client: **enter text.**  Phone Number/s: **enter text.**  Email address: **enter text.** | | |
| Address for the home visit including postcode: **enter text.**  Indicate if this is their own/family home; SDA/SIL; RACF or another place for  the visit: **enter text.**  Assessments are usually conducted by the nurses during a home visit. Are there any concerns that would make a home visit unsafe or unsuitable?  Please specify: **enter text.**  Will there be any communication challenges in completing the assessment? If yes, specify:  **enter text.** | | |
| *Referred by:* | *Name:* Click or tap here to enter text.  *Organisation:* Click or tap here to enter text.  *Referrer role/designation:* Click or tap here to enter text.  *Phone:* Click or tap here to enter text.  *Email:* Click or tap here to enter text.*.*  *Date of referral:* Click or tap to enter a date.  *Check funding information at www.continencenurse.com.au* | | *Funding (circle):*  DVA  *NDIS*  Home Care Package  *STRC*  Other/Private  *NIISQ*  ITC Program |
| **NDIS client information:** | | | |
| NDIS Number (9 digits): **Click or tap here to enter text.**Date report required: **Click or tap to enter a date.**  Is the plan self managed or agency managed or plan managed?: **enter text.** | | | |
| **Plan dates: From:** Click or tap to enter a date.  **To:**Click or tap to enter a date. | | **Plan Manager:** Click or tap here to enter text.  **Email for invoices** Click or tap here to enter text. | |
| **DVA information** | | | |
| Gold Card Number:  **enter text.**  A letter from a Medical Officer must accompany all DVA referrals. | | | |
| Home Care Package Information | | | |
| Home Care Package Provider: **enter text.**  Level of Package (indicate 1, 2, 3 or 4): **enter text.**  Contact details for the Home Care Package Provider.  Phone: **enter text.** Email: **enter text.**  Best email for invoices: **enter text.** | | | |
| Primary diagnosis/disability/ reason for referral: | | | |
| Some basic information will help the nurse triage the referral and prepare for the visit. Please attach or email a Patient Health Summary from the GP if available.  A letter from a Medical Officer must accompany the referral if being referred for catheter changes.  Click or tap here to enter text. | | | |

Refer by email to [admin@cnservice.com.au](mailto:admin@cnservice.com.au) or fax 07 4126 2002