

<p>Referral to:    Specialising in Continence Assessment  DVA Provider No: 9722181T  NDIS Provider No: 4050066722</p>	<b>Client Details</b>		
	<b>Surname:</b>	<b>Given Names:</b>	
	Other names if known as a different name:		
	<b>DOB:</b>		
	<b>Phone:</b>		
	<b>Email:</b>		
	<b>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):</b>		
	<b>Name of person to contact:</b>		
	Relationship to client:		
	Phone: Email:		
<b>Address for the home visit including postcode:</b>			
<b>Postal Address if different from home address:</b>			
<b>This address is for: (circle):</b> Own/family home <input type="checkbox"/> <b>SDA/SIL</b> <input type="checkbox"/> <b>RACF</b>			
<b>Other, please specify:</b>			
<b>Assessments are usually conducted by the nurses during a home visit.</b> <b>Are there any concerns that would make a home visit unsafe or unsuitable?</b>  <b>Will there be any communication challenges in conducting the assessment?</b>			
<b>Referred by:</b>	<i>Name:</i> .....  <i>Organisation:</i> .....  <i>Referrer role/designation:</i> .....  <i>Phone:</i> .....  <i>Email:</i> .....  <i>Date of referral:</i> .....	<i>Funding (circle):</i> <input type="checkbox"/> <b>DVA</b> <input type="checkbox"/> <b>NDIS</b> <input type="checkbox"/> <b>Support at Home</b> <input type="checkbox"/> <b>STRC</b> <input type="checkbox"/> <b>Other/Private</b> <input type="checkbox"/> <b>NIISQ</b> <input type="checkbox"/> <b>ITC Program</b> <i>Check funding information at <a href="http://www.continencenurse.com.au">www.continencenurse.com.au</a></i>	
<b>DVA information</b>			
<p>Gold Card Number: .....</p> <p>A letter from a Medical Officer must accompany all DVA referrals.</p> <p>Are there any community nursing providers in place? Yes/No</p> <p>Is the veteran receiving any other services at home? If yes, please list:</p> <p><b>A letter from a Medical Officer must accompany all DVA referrals.</b></p>			

### NDIS client information:

**NDIS Number:** \_\_\_\_\_ **Date report is needed:** \_\_\_/\_\_\_/\_\_\_

Plan dates: From: ..... to: .....

Circle: Agency Managed      Self Managed      Plan Managed

Plan Manager: ..... Email for invoices: .....

#### Quarterly Funding periods (please enter dates):

Qtr1 To:..... From:..... \$:.....

Qtr2 To:..... From:..... \$:.....

Qtr3 To:..... From:..... \$:.....

Qtr4 To:..... From:..... \$:.....

**As the continence assessments are completed in a block of hours, the funding for the assessment and report writing is best front loaded to be able to allow the nurse to complete the work in a timely manner.**

### Support at Home Information

SAH Provider:.....

Level of Package:..... Quarterly funding allocation: .....

Contact details for SAH Provider/Care Coordinator:

Ph ..... Email: .....

Best email for invoices: .....

### Primary diagnosis/disability/reason for referral:

Some basic information helps the nurse to triage the referral and be prepared for the visit.

Please attach 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.