

Referrer: Please complete this form and send it to RDNS by fax (1300 65 72 65) or post (Level 2, 1155 Toorak Road, HARTWELL VIC 3124).

Referrals from hospitals: Please give this form to your RDNS Liaison nurse if available (if you fax it, please send the original with client/family).

Referrers only: To re-order, email your address and contact details to purchasing@rdns.com.au

CLIENT DETAILS:		(Attach adhesive label if appropriate)
Name:	_____	RDNS UR: _____
	(Given name) (Family name)	(if known)
Address:	_____	
Phone:	_____	Date of birth: _____
Next of kin/contact:	_____	Phone: _____
Interpreter required:	<input type="checkbox"/> No <input type="checkbox"/> Yes: Language spoken at home: _____	
Diagnoses:	_____	
Relevant past history:	_____	
Allergies:	_____	
Pension/DVA number:	_____	(if applicable)
GP details IF NOT REFERRER:	Name: _____	Phone: _____
	Address: _____	Fax: _____

REFERRER DETAILS:	(Complete as appropriate)	The information has been faxed/phoned:
Note: It is RDNS' practice to send GPs a brief letter notifying you of the client's primary nurse and the outcome of our initial assessment.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital / clinic:	_____	Ward / unit: _____
Referrer name:	_____	Phone: _____
		Fax: _____
Planned discharge date:	_____	Requested first visit date: _____
GP/hospital DVA provider no: (This is NOT the client's VX number) _____		
Days you usually visit the client (Community referrers): _____		

RDNS SERVICES/CARE REQUESTED:				(Tick as many as required)
<input type="checkbox"/> Nursing assessment	<input type="checkbox"/> Stomal therapy	<input type="checkbox"/> IV therapy ^Δ	<input type="checkbox"/> HIV/AIDS management	
<input type="checkbox"/> Continence management	<input type="checkbox"/> Personal care	<input type="checkbox"/> Bowel management ^Δ	<input type="checkbox"/> Diabetes management ^Δ	
<input type="checkbox"/> Urinary catheter management ^Δ	<input type="checkbox"/> Aged care	<input type="checkbox"/> Medication management ^Δ	<input type="checkbox"/> Palliative nursing care	
<input type="checkbox"/> General nursing management	<input type="checkbox"/> Technical care ^Δ	<input type="checkbox"/> Pain management	<input type="checkbox"/> Wound management	
<input type="checkbox"/> Other: specify:	_____			
Additional information:	<input type="checkbox"/> ^Δ If you have requested an invasive procedure (eg. IV therapy, catheter management, wound care), please include or attach medical authorisation with specific details (eg. type and size catheter, specific wound regime). (Please include information about infections (eg. MRSA/VRE).			

<input type="checkbox"/> Required equipment has been provided. _____				
<input type="checkbox"/> I have included/attached medical authorisation.				

Name: _____ UR: _____

MEDICAL AUTHORITY TO ADMINISTER MEDICINES: (Please print)

Medicine (Generic name where possible)	Dose	Strength	Frequency	Route

Doctor's name (print): _____ Signature: _____ Date: _____

RELEVANT INFORMATION:

 Please advise if there is any actual or potential risk to RDNS staff security.

Cognitive status: _____
 Contenance: _____
 Mobility: _____
 Client safety issues: _____
 Carer: _____
 At risk: _____
 Access to home: _____
 Other: _____

REFERRALS ALREADY MADE TO OTHER SERVICES:

(If RDNS Liaison nurse involved, no need to complete this section – will be written on Assessment-aeneral.)

Local government: Home Help Respite Personal care
 Home maintenance Other: _____

Allied/Community Health: Community Health Nurse Occupational Therapist Physiotherapist
 Social Worker Other: _____

ACAS (Give details): _____
MAPS/PGAT (Give details): _____
Day centre (Give details): _____
P.A.C: _____
Other: _____

REFERRER:

 (Signature) (Name-please print) (Date)