ST VINCENT'S HOSPITAL
MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

St. Vincent's Health Independence Program Referral Form

UR/Bradma label

Refer to HIP Central for the following HIP Services

- ☐ Cardiopulmonary Rehabilitation
- ☐ Community Rehabilitation Services (including centre-based rehabilitation and Rehabilitation in the Home (RITH))
- ☐ Complex Care Services (formerly HARP)
- ☐ Continence Clinic
- ☐ Falls and Balance Clinic (Multidisciplinary assessment clinic)
- ☐ Cognitive Dementia and Memory Service (CDAMS)
- ☐ Geriatric Medical Specialist Clinic (GMC)*
  **Medical referral required*

Tel: 1300 131 470 Fax: (03) 9231 2202
Email: hipcentralreferrals@svha.org.au

Referral Date:

Refer direct for the following HIP Services

Please call to discuss referral as required.

Barbara Walker Centre for Pain Management
Tel: (03) 9231 4681 Fax: (03) 9231 4660

Polio Services Victoria
Tel: (03) 9231 3900 Fax: (03) 9231 3808

Young Adults Complex Disability Clinic
Tel: (03) 9231 4672 Fax: (03) 9231 3808

****Please attach relevant discharge summaries, discipline handovers, health summary & medication list****

Client Name:	DOB:	Indigenous Status:
Sex assigned at birth:	Gender Identity:	Pronouns:
Address:	Preferred method for communication: Phone / SMS / Email (pls include)	
Tel:	Does client consent to referral? ☐Yes ☐No	Contact person for this referral (*details*):
Country of Birth:	Marital status:	Interpreter required: ☐Yes ☐No Language:
Medicare number:	Pension number:	DVA: ☐Yes ☐No
Next of Kin:	Relationship to client:	Contact number:
Referrer name:		Position/discipline:
Contact number:	Fax:	
Email:		
GP Name:	GP Address:	
Contact number:	Fax:	

ST VINCENT'S HOSPITAL MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

St. Vincent's Health Independence Program Referral Form

UR/Bradma label

Relevant Medical / Surgical History: (diagnosis, onset date, recent investigations) *Attach patient health summary*

Goals / Reason for referral (include patient goals):

Intervention required: ☐ **PT** ☐ **OT** ☐ **SP** ☐ **DIET** ☐ **SW** ☐ **Podiatry** ☐ **Care Coordination**
Other:

If home based therapy requested, reason why?

Current Functional Status: (Please tick and add detail for each below)

Cognition: ☐ Normal ☐ Minor Changes ☐ Confusion ☐ Other

Duration (if anything other than normal): ☐ less than 3/12 ☐ more than 3/12

Continence: ☐ Continent ☐ Incontinent ☐ Bladder - Bowel ☐ Continence Aids

Communication: ☐ Normal ☐ Impaired

Mobility: ☐ Independent ☐ Assisted ☐ Unable ☐ Without Aid ☐ With Aid *type*

Environmental Issues: OT Home Assessment Completed ☐ YES (attach report) ☐ NO

Are other Services involved in client care:

☐ Post-Acute Care	☐ Community Nursing
☐ My Aged Care Package: Level 1-2 Level 3-4	☐ Case Manager: YES / NO Name / Contact details:
☐ NDIS *Contact details*:	☐ Other *(details)*:

For ALL Services, the following is required for referral to be processed (please attach):

☐ Medical, surgical, allied health discharge summaries	☐ Medication list
☐ Discipline handovers	☐ GP / Health summary *(if applicable)*

In addition, for Cardiopulmonary & Cardiac Rehab referrals we require:

☐ Discharge summaries	☐ TTE / TOE results if available
☐ Procedure +/- complications	☐ Advanced Care Plan or treatment limitations *if any*
☐ RFTs if applicable	☐ Home Oxygen requirement

Tel: 1300 131 470 | Fax: (03) 9231 2202 | Email: hipcentralreferrals@svha.org.au