Queensland Government

Metro North Hospital & Health Service
Subacute and Ambulatory Service

Complex Chronic Disease Team Referral

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F

Client Consent

☐ Yes ☐ No Reason if No Date of Referral

Reason for Referral (Tick all that apply)

☐ Pulmonary Rehabilitation
☐ Cardiac Rehabilitation
☐ Head and Neck Cancer
☐ Nurse Practitioner
☐ Medical opinion/review
☐ At risk of re-admission to hospital
☐ At risk of hospital admission
☐ Unstable/poorly controlled chronic disease
☐ Comprehensive assessment of complex/chronic condition
☐ Other

Current Medical History and Progress (or attach medical summary

Previous History

Allergies

☐ Nil Known ☐ Yes please specify

Current Therapies

☐ Radiotherapy ☐ Chemotherapy

Please Indicate Attachments

☐ Medical Summary ☐ RUDAS ☐ GDS ☐ Carer Strain Index
☐ Lawton ADL ☐ Spirometry ☐ MMSE ☐ MOCA
☐ NPIQ ☐ FROP-COM Screen ☐ 6 Minute Walk Test ☐ Pressure Injury Assessment

Alerts/Risks

☐ Is an Alert Form attached?

Please provide details of alerts or risks to staff

Psychosocial Status

Living circumstances ☐ Lives alone ☐ With carer ☐ With family ☐ With spouse/partner ☐ Residential care

☐ Is carer stress evident?

Social Issues

Legal Status

☐ EPOA ☐ Stat Health Attorney ☐ Advanced Health Directive ☐ Guardianship ☐ Acute Resus plan

Which other service has been referred to/is involved?

☐ None ☐ Domiciliary Nurse ☐ Private Service ☐ Housework ☐ Post Acute Care
☐ CBRT ☐ Home Care Package ☐ Allied Health ☐ Family or friends ☐ Meal service
☐ Centre based day respite ☐ Other

DO NOT WRITE IN THIS BINDING MARGIN

Version 1.0 August 2013

COMPLEX CHRONIC DISEASE TEAM

Metro North Hospital & Health Service
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Complex Chronic Disease Team Referral

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐M ☐F

Referrer Site Details

Ward | Program/Unit

Admitting Consultant | Referring Officer

Telephone

GP Details (if GP details are same as Referrer, please write "As Above" in Practice)

Practice | Name

Phone | Fax

Client Details

Title | Name | Sex ☐M ☐F | Date of Birth

Address

Telephone | Mobile

Returning to registered address ☐Yes ☐No

Indigenous Status

Does the client require an interpreter? ☐Yes ☐No ☐Unknown

If yes, language spoken

Medicare No | Expiry Date

Government Benefit | Card No

Health Insurance | Card No | Company

Next of Kin/Other Contact Details

Name | Address

Telephone | Mobile

Relationship to Client

DO NOT WRITE IN THIS BINDING MARGIN

REFERRAL SUBMISSION

Brisbane City Council area
Fax: 3139 6522
Enquiries: 1300 658 252

Moreton Bay Regional Council area
Fax: 3049 1260
Enquiries: 1300 658 252