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| ABN 12 693 361 6451a, 2019 Gold Coast Hwy, Miami, 4220, QLDPh: 1300 225 886 | Fax: (07) 5599 2977Email: referral@asterhomecare.com.au |  |

Aster Home Care is a health care provider specialising in Veterans health care providing clinical and personal requirements in their own home.

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| **CLIENT DETAILS *(sticker if applicable):*** |
| Title: (tick) [ ]  Mr. [ ]  Mrs. [ ]  Miss [ ]  Other  |
| Surname:  | First Name:  |
| DOB:  | DVA No.: |
| Address: |
| Phone:  | Mobile: |
| **ADDITIONAL CONTACT DETAILS / NOK (NEXT OF KIN):** |
| Surname:  | First Name: |
| Relationship: |
| Address:  |
| Phone:  | Work / Mobile: |

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| **PATIENT’S GENERAL PRACTITIONER *(if known):***  |
| Name:  | Clinic Name: |
| Clinic Address: |
| Phone:  | Fax: |
| **REASON FOR REFERRAL / PERTINENT HISTORY FOR NURSING CARES:** |
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| **ATTACHMENTS *(as available):*** |
| Discharge Summary [ ]  Yes [ ]  No | Incontinent [ ]  Yes [ ]  No | Social Worker Notes [ ]  Yes [ ]  No |
| Medication Summary [ ]  Yes [ ]  No | SPC / IDC [ ]  Yes [ ]  No | Adv. Health Directive [ ]  Yes [ ]  No |
| Wound Charts [ ]  Yes [ ]  No | OT, Physio Notes [ ]  Yes [ ]  No | EPOA [ ]  Yes [ ]  No |

|  |  |
| --- | --- |
| Tentative Discharge Date *(if applicable):* | Tentative Commencement Date *(if known):* |
| Signature: | Title: |
| Name: | Date: |

**COMMUNITY NURSING SERVICE CONSENT FORM**

**Referrer Consent for Service Commencement**

**Client Information:**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referrer Information:**

Referring Organisation/Healthcare Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Referrer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Service Provider Details:**

Community Nursing Service Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent Statement:**
I, the undersigned, as the referring healthcare provider/organisation, confirm that I have obtained verbal or written consent from the client (or their authorised representative) to share relevant health information with the community nursing service for the purpose of initiating and coordinating care.

I authorise the community nursing service to:

* Contact the client and/or their authorised representative to arrange care services.
* Access and use the necessary health information for assessment, planning, and delivery of nursing care.
* Share appropriate information with relevant healthcare professionals involved in the client’s care to ensure continuity and quality of service.

I understand that this consent allows the community nursing service to commence care and provide necessary interventions in accordance with professional standards and confidentiality policies.

**Referrer Authorisation:**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client acknowledgement:**
I acknowledge that I have been informed about the referral to the community nursing service and consent to the exchange of relevant health information for the purpose of my care.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I nominate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to be contacted on my behalf to arrange commencement of services and needs. **Leave blank if not applicable.**

**\*\*If client unable to sign Authorised Representative Acknowledgment: \*\***

I acknowledge that I have been informed about the referral to the community nursing service and consent to the exchange of relevant health information for the purpose of my care.

**Signatory authorisation: Enduring Power of Attorney please attach EPOA.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Privacy and Confidentiality Notice:**
All information shared will be handled in accordance with privacy legislation and organisational policies to ensure client confidentiality.