For general enquiries contact Administration Officer
Blue Care Allied Health Access Project
P: 07 3891 8040
F: 07 3891 8042

RESIDENTIAL AGED CARE ACCESS

Allied Health Professional

RACF / GP: Please fax this referral to Blue Care Customer Service Centre F: 1800 170 446	**AHP:** Please include the purchase order number on your invoice to Blue Care

RACF Details

Name:	**Address:**
Telephone:	

Referral to: *(please tick one)*
☐ Psychology ☐ Social Work ☐ Physiotherapy ☐ Dietetics
☐ Speech Pathology ☐ Occupational Therapy ☐ Other: _____

Resident Details (Resident sticker is acceptable)

Surname: _____
First name/s: _____
DOB: _____
Gender: ☐ M ☐ F

ACFI Categories
ADLs: ☐ low ☐ medium ☐ high
Behaviour: ☐ low ☐ medium ☐ high
Complex Health Care: ☐ low ☐ medium ☐ high

Does the resident identify as being of Aboriginal and/or Torres Strait Islander origin?

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Not Aboriginal and Torres Strait Islander

Ethnicity: _____ **How well is English spoken?** ☐ Very well ☐ Well ☐ Not well ☐ Not at all

Primary language spoken other than English: _____ **Is an interpreter required?** ☐ Yes ☐ No

Eligibility:

Does the Resident have private health insurance with Extras that will fund this treatment? ☐ Yes ☐ No

Does the Resident have a DVA entitlement card? ☐ Yes If yes, what colour: _____ ☐ No

Does the Resident qualify for Allied Health services through Chronic Disease Management items (CDM)? ☐ Yes ☐ No

How many CDM items are available for this referral? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Referral Details

Referral for one (1) consultation for assessment and recommendation by the by the Allied Health Professional for up to five (5) consultations.

Patient History: (Medical, Surgical, Social, Family)

Presenting Issues: (including any recent assessment results)

Expected Outcomes:

Referring Senior Nursing Staff / Clinician Details

Is evidence of the consent given for this referral by the Resident or their Substitute Decision Maker held by the facility? ☐ Yes ☐ No

Name: (Please print)	**Designation:**
Signature:	**Date:**

Provider Use Only	Purchase Order No:	