Queensland Government

Metro South Health

Nurse Navigator Generalist Referral

Fax completed form to : 1300 364 248

Family name:

Given name(s):

Address:

Phone:

Date of birth: Sex: ☐ M ☐ F

Patient Consent: Is the patient aware of this referral: ☐ Yes ☐ No

Primary Reason for Referral

Tick all that apply below:

Chronicity

☐ >6 months ☐ 2 or more chronic conditions ☐ Mental Health condition

Complexity

☐ Requires skilled care in any location: home, work
☐ Been readmitted within 28 days of discharge x 2
☐ 2 or more unplanned inpatient admissions >7 days
☐ Anticipated need for multiple specialities

Fragility

☐ Severe life-threatening condition
☐ Failure of equipment placing the patient at risk
☐ Multiple self-discharge against medical advice
☐ Risk of significant clinical deterioration
☐ Actual / risk of multiple "did not attend" (DNA) to health services

Fragility Increased by

☐ Geographical / transport isolation
☐ Social complexity of significance
☐ Poor support systems
☐ High risk of carer burnout
☐ Homelessness or at risk of homelessness
☐ Disability
☐ Culturally and linguistically diverse
☐ Child Protection concerns
☐ DV concerns
☐ Functional impairment
☐ Lower literacy
☐ Mental Health issues:
☐ stable ☐ unstable ☐ complex

Comments:

Intensity of Care

☐ Complex medication regime.
☐ Dependence on medical aids; e.g. oxygen, suction, PEG, non-invasive ventilation, catheters.
☐ Partial or full dependence on carers for all ADL's.

Demographics

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Aboriginal or Torres Strait Islander origin: ☐ Yes ☐ No

Born in a country other than Australia: ☐ Yes – which country:

Speaks / understands English: ☐ Yes ☐ No If no, language:

Is Interpreter required: ☐ Yes ☐ No

Emergency Contact

Name: Relationship:

Address:

Email: Phone:

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Medical Diagnosis

Main purpose of referral is for patient to receive:

☐ Improved health literacy ☐ Case coordination ☐ Establish regular review of goals
☐ Linkage to appropriate service ☐ Coaching for self-management

List medical concerns or planned interventions:

Additional referral information (e.g. medical/family/care needs, ACAT assessed):

Please attach recent health summary, medication list and applicable documents:

☐ ACAT ☐ Discharge summary ☐ GP Management plan ☐ Health summary ☐ Medication list
☐ Advance Care Plan / Statement of Choices

☐ Current inpatient – estimated discharge date:

Hospital: Ward:

Please provide details of other professionals involved in the care of this patient:

Name / organisation	Role	Phone	Email

Referral Source

Name: **Designation:**

Agency / Provider / Organisation address:

Phone: **Email:**

Signature: **Date:**

Intake and Access Purposes Only

Date received: ☐ Accepted ☐ Not accepted ☐ Referrer notified

Allocated to: Accepted by:

Processed by (name): Designation:

Signature: Date:

☐ HBCIS registration & Nurse Navigator Service alert

DO NOT WRITE IN THIS BINDING MARGIN