



Referral Form

Partnerships for Children ACE Program

UR NUMBER
SURNAME
GIVEN NAME
DATE OF BIRTH

Affix patient label

Please fax to 9345 6231 then call the Intake Liaison on ext 5674 to confirm receipt of the referral

Unit: _____

Referral Date: ___/___/___

Consultant: _____

Expected Discharge Date from RCH: ___/___/___

Primary Diagnosis: _____

Subsequent Diagnoses: _____

Summary of client's condition, relevant past history, devices & prognosis:

Triggers likely to result in an Emergency Department Presentation:

Social Situation:

Who does the child live with?

Parents Grandparents Foster Parents Other: _____

Does the family require an interpreter? Yes No Language: _____

Parent/Carer Competency:

Are parents/carers competent in care required? Yes No

If no, are they able to be educated? Yes No

Is the child able to participate in the required procedure? Yes No

Are the parents/carers compliant with the care required? Yes No

If no, please provide details: _____

Are there any other factors that you are aware of that may impact on the families ability to care for the child (ie child protection involvement, own health concerns)?

Does the child have a community based Case Manager? Yes No

If yes, please provide the Case Manager's contact details:

Are there any other programs involved with this family (i.e. Family Choice, Specialist Children's Services, Strengthening Families) Yes No

If yes please provide name of program/s and contact person: _____

Communication with treating medical team:

Please indicate level of communication desired.

- After all contact with families
- After any presentation to RCH
- Other: _____

Contact person: _____ After hours contact details: _____

Email: _____

Referrer's details:

Name: _____ Position: _____

Signature: _____ Phone/pager: _____

Email: _____

Office use only:

Admit

- Accepted to ACE (date): _____
 - Rejected (date) _____ Review in 3/12
- Family Letter (date) _____
- Family Consent (date) _____
- Referrer informed of status (date) _____
- Consultants informed of status (date) _____
- GP Letter (date) _____
- Entered on TCM database/Active Client List (date) _____
- Create Care Plan/Update to desktop (date) _____
- IBA / HAS alerts updated _____
- Notification to RCH @ Home (date) _____
- MAS referral (date) _____
- Note in Communication Book (date) _____

Discharge

- Discharged from ACE (date): _____
- Emailed Consultants (date) _____
- Phoned/Letter sent to parents (date) _____
- Discharge table complete (date) _____
- Written copy removed from current files and transfer to Discharged/Deceased files (date) _____
- Removed from ACE Client List (date) _____
- Removed Care Plan from TCM Documents folder (date) _____
- IBA / HAS alerts removed (date) _____
- MAS notified (date) _____
- RCH@HOME/FCP/Palliative notified (date) _____
- Note in Communication Book (date) _____
