The Royal Children's Hospital Melbourne

Complex Care Hub Referral

Fax all referrals to (03) 9345 6600
Telephone enquires (03) 9345 6868 (Monday – Friday 8:00am – 5:30pm)

Please note: A typed referral is required.

It is the responsibility of the referrer to have a conversation with the family to discuss their potential inclusion within the service.

The referral will be acknowledged within three days.

Complex Care Hub Intranet link:
https://www.rch.org.au/complex-care-hub/

Patient Details		
Referral date	**MRN**	**Date of birth**
Given name	**Surname**	
Address		
Suburb	**Post code**	
Telephone	**Email**	
Medicare number ___ ___ ___ ___-___ ___ ___ ___ ___-___ /___	**Medicare expiry date**	
Referrers Details		
Position title	**Full name**	
Name of referring organisation	**Department**	
Suburb	**Postcode**	
Telephone	**Fax**	
Email		
Parent/Guardian Details		
Primary contact		
Full name	**Relationship**	
Address		
Suburb	**Postcode**	
Telephone	**Email**	
Interpreter required ○ **No** ○ **Yes**	**If yes, what is the primary language**	
Secondary contact		
Full name	**Relationship**	
Address		
Suburb	**Postcode**	
Telephone	**Email**	
Interpreter required ○ **No** ○ **Yes**	**If yes, what is the primary language**	
GP Details		
Full name	**Hospital/GP practice**	
Address		
Telephone	**Email**	
Paediatrician / Specialist Details		
Full name	**Hospital/GP practice**	
Address		
Telephone	**Email**	

Consent

I have informed the family of this referral and they have given consent for Complex Care Hub to gather information from the child's care team to assist in the determining of eligibility. ○ **Yes** ○ **No**

Complex Care Hub Referral MR106/C

Child's diagnosis / Past medical history

Child's diagnosis / Past psychological history / Risk factors

Are there any significant factors that you are aware of that may impact on the family's care of the child? E.g. child at risk, family violence, drug and/or alcohol use.

Eligibility

1. **Chronicity:** Is the child's condition expected to be present for 12 months? ○ Yes ○ No
2. **Complexity:**

a. **Medical:** Will the child have more than 10 medical appointments in a year? ○ Yes ○ No

Teams involved	***What condition/need are they managing?***

b. **Psychosocial:**

Are there significant difficulties in areas of carer health, geographical isolation or disability? ○ Yes ○ No

Does it impact on their ability to care for the child? ○ Yes ○ No

Details: _____

3. **Instability:** Has the child had, or is expected to have, more than one emergency admission in 12 months? ○ Yes ○ No
4. **Functional limitations:** Does the child's condition impact on participation in independent age-appropriate activities? ○ Yes ○ No
5. **Fragility:** Has the child had more than 5 hospital admissions in 12 months or 30 inpatient days in 6 months? ○ Yes ○ No
   - **a.** Number of admissions 12/12: _____
   - **b.** Number of inpatient days 6/12: _____
6. **Intensity:** Does the child have an interventional health care need and require a technology or procedure in their home? ○ Yes ○ No

If you have answered YES to "5. Fragility" or "6. Intensity", please complete the "Critical Care Needs" and "Additional Needs" section below. If NO, please continue to the "Complexity Factors" section.

Critical Care Needs

Nutrition

- ◯ Needs help
- ◯ PEG supplements
- ◯ All PEG or NG bolus feeds
- ◯ PEJ or NJ or continuous feeds
- ◯ TPN: How often? _____

Neurological (events requiring treatment)

- ◯ Event frequency
- ◯ Emergency medication: How often? _____
- ◯ Overnight events: How often? _____
- ◯ Life threatening events requires airway support: How often? _____

Skin

- ◯ Pressure risk
- ◯ Weekly treatments
- ◯ Daily dressing
- ◯ Life threatening

Psychology

- ◯ Low mood
- ◯ Reactive anxiety
- ◯ Self-harm
- ◯ Risk to self and others

Respiratory

- ◯ Medication: How often? _____
- ◯ Low Flow Oxygen: Hours per day _____ ◯ Sleep only
- ◯ Suction: How often? _____ ◯ Life threatening airway obstruction
- ◯ BiPAP / CPAP / High FLOW / Vent: Respiratory support type: _____ Hours required: _____

Additional Needs

Communication

- ◯ Some support
- ◯ Only familiar can understand
- ◯ Rarely communicates
- ◯ No skills

Continence/Renal

- ◯ Stable, stoma
- ◯ Clean intermittent catheters
- ◯ Incontinent despite treatment
- ◯ Dialysis dependent

Mobility

- ◯ Needs support
- ◯ 1 person transfer
- ◯ 2 person transfer
- ◯ Immobile / hoist

Medication

- ◯ Routine
- ◯ Variable and overnight
- ◯ Severe pain 2 hourly
- ◯ Infusion: ◯ Type duration ◯ Routine
- ◯ Route

Complexity Factors

Language

- ◯ Some difficulty
- ◯ No English

Interpreter Required

Carer Health

- ◯ Minor Concern
- ◯ Impact Caring

Housing/Isolation/Alternative Carer

- ◯ Some factors
- ◯ Multiple factors

Adverse life event: Child/Family

- ◯ No
- ◯ Yes (If Yes, please provide details)

_____

_____

_____

Comments

Detailed referral reason