The Royal Children's Hospital Melbourne

# Family Healthcare Support (FHS) Homecare Referral

**Email all referrals to:** homecare.referrals@rch.org.au
**Telephone enquiries to (03) 9345 4664** (Monday – Friday 8:00am – 4:30pm)
**Homecare Program Intranet link:**
https://www.rch.org.au/fhs/homecare-program/Homecare_program_referrals/

The Royal Children's Hospital Homecare Program (HCP) is a fee for service program designed to provide specialised training on specific interventional care needs for children with increased complexities to allow them to be safely cared for in their own environment. This is not limited to the home environment but may also include Kindergartens, Day Care Centres and other Learning facilities. Training is delivered by specialised Paediatric Registered Nurses.

## Part A

Required Fields*

### Homecare Program Consent

| | |
|---|---|
| Referral Date: * | |

### Patient Details

| | | | |
|---|---|---|---|
| First Name: * | | Last name: * | |
| Date of Birth: * | | RCH MRN: * | |

### Program Consent

| | | | |
|---|---|---|---|
| Parent/Guardian name: * | | | |
| Relationship to child: * | | Date of Consent: * | |
| Parent/guardian Signature: * | | | |
| Verbal Consent Received: | ○ Yes ○ No | Date of Verbal Consent: | |
| Verbal consent received by: | | | |

### Referral Checklist

**It is essential that all necessary documentation is included with the referral**

- ☐ Part A (Consent)
- ☐ Part B (Patient Details)
- ☐ Part C (Medical & Care Plan's / Supporting documentation if required)
- ☐ Part D (Carer)

FHS Homecare Referral MR104/C

## Part B

Required Fields*

### Parent/Guardian Details

| | | | |
|---|---|---|---|
| Full Name: * | | Relationship: | |
| Address: * | | | |
| Suburb: * | | Post Code: | |
| Telephone: * | | | |
| Email: * | | | |

### Referrers Details

| | | | |
|---|---|---|---|
| Referrer Name: * | | Referral Date: * | |
| Position: * | | Telephone: * | |
| Email: | | | |

### Treating Medical Practitioner (GP/ Paediatrician/Specialist)

| | | | |
|---|---|---|---|
| Full Name: | | | |
| Hospital/ Practice: | | | |
| Address: | | | |
| Telephone: | | Fax: | |
| Email: | | | |

### Social Circumstances

| | | | |
|---|---|---|---|
| Cultural Considerations: | | | |
| Family Circumstances/ Psychosocial: | | | |
| Allocated Social Worker: | | | |
| Email: | | Telephone: * | |
| Interpreter Required: | ○ Yes ○ No | Language: | |

## Part C

*Required Fields

| Child's Diagnosis/Past Medical History* |
|---|
| |

### Training Needs

| **Nursing Training:*** (Please indicate requirement) | | |
|---|---|---|
| ○ Seizure Management | ○ Emergency Medication | ○ VP Shunt |
| ○ Tracheostomy Care | ○ Ventilation Support | ○ Oxygen therapy |
| ○ Hyper/Hypoglycemia | ○ Oral/Nasal Suctioning | ○ Asthma Management |
| ○ Naso-pharyngeal airway | ○ Baclofen pump | ○ Pulse Oximetry |
| ○ NGT/NJT | ○ Catheterization | ○ Ostomy |
| ○ PEG/PEJ | ○ CVAD | |
| ○ Other (list): | | |
| **Relevant Care / Action Plans:*** (Please ensure all plans are attached and up to date) | | |
| ○ Epilepsy management Plan (EMP) | ○ Epilepsy Medication Management Plan (EMMP) | ○ Diabetes Action Plan |
| ○ Asthma Action Plan | ○ Anaphylaxis Action Plan | ○ Allergy Action Plan |
| ○ Other: | | |
| Is there an Advanced Care Plan in place? | ○ Yes ○ No | |
| Is there a Behaviour Management plan in place? | ○ Yes ○ No | |
| Allergies: | | |
| **Allied Health Training:*** (please indicate requirement) | | |
| Do you require RCH Allied Health training? (Please tick no if your community Allied Health Provider will provide training) | ○ Yes ○ No | |
| ○ Chest Physiotherapy | ○ Cough Assist | ○ Hoist/Manual Handling |

## Part D

*Required Fields

***To be completed in collaboration with Facility Key Contact or Support Worker Agency***

### Facility Contact Details

| | | | |
|---|---|---|---|
| Facility Type: * | ○ Kindergarten ○ Day Care/ELC ○ School ○ In Home<br>○ Other:_____ | | |
| Facility Name: * | | | |
| Facility Key Contact: * | | | |
| Funding Source: * | ○ NDIS ○ KIS<br>○ Palliative ○ Self-Funded<br>○ Other:_____ | Funding approval status: * | ○ Approved ○ Pending<br>○ Other: _____ |
| Telephone: * | | Email: * | |
| Address: * | | | |
| Suburb: * | | Postcode: * | |
| Total Number of Staff Members to be trained:* | | Is this child new to your facility?: * | ○ Yes ○ No |

### Facility Support Staff Details

| | Support Workers Names | Will the staff member be performing the child specific medical intervention/s for this child at least once per fortnight? | Has this support worker previously completed training for this child under the RCH HCP? |
|---|---|---|---|
| **Name of support workers to be trained *** | **1.** | ○ Yes<br>○ No | ○ New<br>○ Experienced |
| | **2.** | ○ Yes<br>○ No | ○ New<br>○ Experienced |
| | **3.** | ○ Yes<br>○ No | ○ New<br>○ Experienced |
| | **4.** | ○ Yes<br>○ No | ○ New<br>○ Experienced |
| | **5.** | ○ Yes<br>○ No | ○ New<br>○ Experienced |
| | **6.** | ○ Yes<br>○ No | ○ New<br>○ Experienced |

## *Billing Details*

**NDIS Package Information** (Only required to be completed for NDIS funded training *)

| | | | |
|---|---|---|---|
| NDIS Plan Number: * | | Start and Finish Dates: * | |
| NDIS Support Coordinator: * | | | |
| Billing Telephone: * | | Billing Email: * | |
| Billing Address: * | | | |
| Billing Suburb: * | | Postcode: * | |