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| **Identify** | | |
| **About the Resident:** | | |
| **Grampians Region**  **Residential in Reach Referral** | **Surname:** |  |
| **Given Names:** |  |
| **DOB:** |  |
| **Gender at birth:** |  |
| **Medicare Number:** |  |
| **Residential Aged Care Home (RACH) name:** |  |
| **RACH Address:** |  |
| **Does the resident identify as Aboriginal or Torres Strait Islander?** | Choose an item. |

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| **About the Referrer:** | |
| **Name:** |  |
| **Role:** |  |
| **Organisation name:** |  |
| **Phone:** |  |
| **Email:** |  |
| **Date and time of referral:** |  |
| **Have you notified the residents GP of RIR referral? Yes/ no** | Choose an item. |
| **GP name and phone:** |  |
| **Urgency of referral (select one option)** | |
| **Please select from drop down menu** | \* if urgent selected complete referral and call RIR 7 days week, 7:30am-4pm ph. 0478305011, or 11 am-730pm ph. 0417199135  Choose an item. |

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| **Situation** |
| **Please provide reason for referral/ presenting problem:** |

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| **Background** | |
| **Does the resident have an**  **Advanced Care Plan or Advance Care Directive?** | Choose an item. |
| **What matters to the resident and their family?** | Include here what the resident/family previously stated is important to them i.e. what are the resident’s health care goals? |
| **Past Medical history:** |  |
| **Allergies/ alerts:** |  |
| **Assessment:** | |
| **Spo2:** |  |
| **Respiratory rate:** |  |
| **Heart rate:** |  |
| **Blood pressure:** |  |
| **Temperature:** |  |
| **Blood glucose level (if relevant)** |  |
| **Confusion (Yes/no)** | Choose an item. |
|  | If yes, has a delirium assessment been completed? I.e. 4AT  Choose an item.  **Assessment attended and Score:** |
| **Other:** | i.e. responsive behaviours, specific GP recommendations |

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| **Request/ recommendation** | |
| **What response are you requesting from RIR? Please select one option from below:** | Choose an item |
| **If the residents deteriorates, please escalate care locally** | |

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| Grampians Region RIR only | |
| Date referral received: |  |
| Referral triage completed by: |  |
| Referral status: | Choose an item. |
| RACH notified of referral outcome: yes/No | Choose an item. |
| Date notified: |  |