Rehabilitation @ Home Referral Guidelines

Remedy
HEALTHCARE IN YOUR HOME

Meets Hospital Substitution Criteria – substitutes for an inpatient rehabilitation ward stay

Check health fund financial eligibility

Referrals

Minimum standards to support safer, faster and better patient care:

- ✓ **ALL sections of the referral form must be completed for a referral to proceed**
- ✓ **Specialist name and contact details must be documented** as they maintain clinical governance throughout the program
- ✓ Diagnosis and relevant past medical history
- ✓ Signature on referral form - **a clinician must sign referral form**
- ✓ Expected **length of program** to be documented on referral form

Please do not discharge your patient home until Remedy has **confirmed approval and service capacity.**

Always refer early especially for clients who live in regional and remote areas

SMART Goals of each clinical service must be provided on the referral form.
These goals can be identified by any member of the patient's clinical team.

Please list the clinical and non-clinical service requirements including **start date, frequency and duration of care**

Please arrange ongoing discharge plan for clients that may require longer term community nursing &/or personal care

If applicable, **discharge patient home with consumables** to attend to dressing change or removal of staples/sutures.

Complete online referral form at refer.remedyhealthcare.com.au.

Alternatively, send PDF referral to getbetter@remedyhealthcare.com.au or call 1300 734 224 to speak to a triage clinician.

Please call & discuss urgent referrals

Please see over for form information

Get in touch

Call 1300 734 224 or email **getbetter@remedyhealthcare.com.au** to speak to a triage clinician

Rehabilitation at Home Referral Form

Remedy HEALTHCARE IN YOUR HOME

Phone 1300 734 224 | Fax 1300 734 221 | Email getbetter@remedyhealthcare.com.au

1. Patient details

First name		Last name	
Date of birth		Gender	
Address for discharge			
State		Postcode	
Phone number		Email	
Cultural/language considerations			

Is the patient of Aboriginal and/or Torres Strait Islander origin?

- ☐ Aboriginal ☐ Torres Strait Islander
- ☐ Both Aboriginal and Torres Strait Islander
- ☐ Neither Aboriginal nor Torres Strait Islander origin
- ☐ Not stated / inadequately described

Next of Kin

First name		Last name	
Phone number		Relationship	

2. Funding details (PLEASE SELECT HOW THIS PROGRAM WILL BE FUNDED)

☐ **Private health fund** ☐ **Hospital funded**

Health fund name	
Membership number	

☐ **Compensation body/Third party**

Compensation Body Name	
Claim number	
Case manager name	
Case manager phone	
Case manager email	

3. Medical details

Hospital admission date		Anticipated discharge date	
Hospital name			
Primary diagnosis and interventions / surgical procedures (if applicable)			
Past medical history			
Any complications during current admission	☐ Yes ☐ No	Details:	
Any cognitive impairment/delirium	☐ Yes ☐ No	Details:	
Allergies			

Infection control alerts: ☐ MRSA ☐ Help B/C ☐ VRE ☐ HIV ☐ COVID-19 ☐ Influenza ☐ None ☐ Other (specify):

Specialist name			
Specialist phone		Specialist email	
GP name & clinic			
GP phone		GP email	

SEE OVER TO COMPLETE FORM

Rehabilitation at Home Referral Form

Patient name:	
Patient DOB:	
Patient address:	

Phone 1300 734 224 | Fax 1300 734 221 | Email getbetter@remedyhealthcare.com.au

3. Medical details (CONTINUED)

Home visit staff safety checklist

History of aggression or violence?	☐ Yes ☐ No	History of inappropriate behaviour?	☐ Yes ☐ No
History of illicit substance abuse?	☐ Yes ☐ No	Any other risks for home visiting?	☐ Yes ☐ No
Details:			

4. Care needs

Transfers	☐ Independent ☐ Supervision ☐ 1x assist ☐ 2x assist ☐ Immobile ☐ Other (specify):
Mobility on discharge	☐ Independent ☐ Supervision ☐ 1x assist ☐ 2x assist ☐ Immobile ☐ Other (specify):
Walking aid	☐ Nil aid ☐ Walking stick ☐ Crutches ☐ Frame ☐ Wheelchair ☐ Other (specify):
Falls risk	☐ Yes ☐ No — Details (if yes):
Weight-bearing Status	☐ WBAT ☐ Partial ☐ Protected ☐ Touch WB ☐ Non-WB ☐ No restrictions
Precautions/contraindications	
Social history	
Additional information	
Supporting documentation (if applicable):	☐ Hospital discharge summary / allied health report ☐ Specialist protocol with precautions / contraindications listed

5. Rehabilitation at home service requirements

Patient discharged from: ☐ Acute ward ☐ Inpatient rehabilitation

The patient would otherwise stay admitted in hospital for _____ day/s without home services

Service	Start date	Frequency (per week)	Program length (weeks)	SMART goals of clinical services requested
☐ Physiotherapy				
☐ Occupational therapy				
☐ Dietetics				
☐ Rehab nursing				
☐ Personal care				
☐ Home help				
☐ Meals				

☐ This patient **does not wish, or is not clinically suitable** to receive virtual / hybrid care

6. Authorisation and referrer details

By signing and sending this referral I declare that:

- The hospital treating specialist declares that the patient is medically stable.
- The patient is suitable to safely engage in home-based care.
- The patient has consented to receiving Remedy Healthcare services at home and has consented to their personal and health information being shared with Remedy Healthcare and the health fund nominated in this form, or the health fund's authorised agent.
- The patient has consented to Remedy Healthcare and the health fund nominated in this form contacting the patient, including by electronic means, to ascertain funding eligibility, confirm receipt and facilitate participation of the relevant services.
- The information provided in this form is complete, true and correct to the best of my knowledge.

Referrer name		Referrer organisation	
Referrer role title		Referrer phone	
Referrer email		Additional email	
Referrer signature		Date	

SUBMIT VIA EMAIL