MORELAND HOME CARE

Hospital Discharge Referral Form
High Intensity Supports & SIL

Phone: 0451 145 632
Email: participants@morelandhomecare.com.au
Website: morelandhomecare.com.au
NDIS Registration: 4-4331-3398

SECTION 1: PARTICIPANT INFORMATION

Participant Name: _____ DOB: _____

NDIS Number: _____ Plan Start Date: _____

Support Coordinator: _____

Coordinator Phone: _____ Coordinator Email: _____

SECTION 2: HOSPITAL & DISCHARGE INFORMATION

Hospital Name: _____

Ward/Unit: _____ Current Room: _____

Discharge Planner: _____

Planner Phone: _____ Planner Email: _____

Preferred Discharge Date: _____

☐ Urgent ☐ Standard

SECTION 3: MEDICAL & CARE REQUIREMENTS

Primary Diagnosis: _____

For urgent placements, call: 0451 145 632
Please email completed form to: participants@morelandhomecare.com.au
Response time: Within 2 hours during business hours | Urgent placement available for urgent cases

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Secondary Diagnoses: _____

Current Medications:

Medical Equipment Required: _____

SECTION 4: HIGH INTENSITY CARE NEEDS

Please check all that apply:

- ☐ Complex bowel care
- ☐ Catheter management
- ☐ Wound care/dressing changes
- ☐ Stoma care
- ☐ Tracheostomy care
- ☐ Ventilator support
- ☐ PEG feeding
- ☐ Seizure management
- ☐ Diabetes management
- ☐ Challenging behaviors
- ☐ 24/7 supervision required
- ☐ Other:

SECTION 5: BEHAVIOURAL SUPPORT

Behaviour Support Practitioner: _____

BSP Phone: _____ BSP Email: _____

Current Behaviour Support Plan in place? ☐ Yes ☐ No

Risk Level: ☐ Low ☐ Medium ☐ High

SECTION 6: ALLIED HEALTH PROFESSIONALS

Physiotherapist: _____

Occupational Therapist: _____

Speech Pathologist: _____

Psychologist/Psychiatrist: _____

Other: _____

SECTION 7: ADDITIONAL INFORMATION

Special Considerations / Care Notes:

Cultural / Religious Considerations:

Preferred Language: _____ Interpreter Required? ☐ Yes ☐ No

SECTION 8: DOCUMENTS TO BE PROVIDED

Please attach or provide the following documents:

☐ Consent Form

☐ Hospital discharge summary

☐ Current NDIS plan

☐ Risk assessment

☐ Behaviour support plan (if applicable)

☐ Medication chart

☐ Allied health reports

☐ GP management plan

☐ Medical equipment specifications

SECTION 9: REFERRER DETAILS

Referrer Name: _____

Position/Title: _____

Phone: _____ Email: _____

Date of Referral: _____ Signature: _____

CONFIDENTIALITY NOTICE

This form contains confidential participant information. Please handle in accordance with privacy legislation and NDIS Practice Standards. By submitting this referral, you confirm that consent has been obtained from the participant or their legal guardian.