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Alfred Health UR

CMI UR

REFERRAL TO WOMEN'S RECOVERY NETWORK (Wren) FOR ADMISSION

Consumer details					
Last name*		First name/s*		Date of birth*	

*mandatory fields

- Wren supports women living in Victoria aged 18 years and over, with a range of issues including experiences of trauma and abuse, eating disorders and perinatal mental health concerns
- The consumer will be contacted on receipt of this referral

Enquiries / return referral to: T 03 9279 3759 F 03 9256 8364 E referral@womensrecovery.org.au

Care stream consumer is being referred to			
☐ General	*Do not complete Appendix A or B*		
☐ Perinatal	*Complete Appendix A*		
☐ Eating Disorders	*Complete Appendix B*		
Consumer has verbally consented to this referral*	☐ Yes ☐ No	**Referral date***	

Consumer information					
Sex	☐ Female ☐ Male ☐ Other	Gender Identity	☐ Female ☐ Male ☐ Non binary ☐ Not stated ☐ Prefer not to answer		
Marital Status	☐ Never married ☐ Divorced ☐ Widowed ☐ Separated ☐ Married / De facto ☐ Not stated ☐ Prefer not to answer			Religion	☐ Not stated ☐ Prefer not to answer
Address					
Telephone/s		Email			
Preferred method of communication	☐ Email ☐ Telephone ☐ SMS ☐ Letter ☐ Exclude mail out				
Medicare number		Ref	Exp	NDIS number	
Interpreter	☐ Yes	Language			
Indigenous status	☐ Not Aboriginal or Torres Strait Islander ☐ Torres Strait Islander not Aboriginal ☐ Aboriginal not Torres Strait Islander		☐ Aboriginal and Torres Strait Islander ☐ Prefer not to answer ☐ Not specified		
Cultural considerations / support needs					
Any dependents / children in their care?	☐ Yes, *Details*				
Contact / support person	Name				
	Relationship		Telephone		
Nominated Support Person	Name				
	Relationship		Telephone		
Advance Statement of preferences	☐ Yes ☐ No	*If yes, attach*			

Current supports	Name	Address
General Practitioner		
Psychiatrist		
Psychologist		
Area Mental Health Service		
Maternal Child Health Nurse		
Dietitian		
Other (*eg, NDIS coordinator)*		

Referrer Details					
Referring clinician name				Designation	
Organisation name and address					
Telephone		Fax		Email	

Dec 2023
Source: AlfredHealth.org.au

EMR: Admission / Admission Request

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Last name*		First name/s*		Date of birth*	

Legal / forensic	
Current forensic or legal status (*incl child protection order, IVOs)*	
To the best of your knowledge, have any Child Protection notifications been made?	☐ Yes ☐ No *Details*
Case worker and contact (*if applicable*)	

Referral	
Reason for referral	
Goals for admission	
Mental Health history*	
Alcohol or drug history & current use	
Medical history*	
Current physical health problems	
Current medications / doses* (*incl over the counter medications)*	

*separate documents can be attached

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Last name*		First name/s*		Date of birth*	

Risk Assessments		
Suicide	Imminent ☐ Yes ☐ No High ☐ Yes ☐ No *Details*	
Deliberate Self Harm	Imminent ☐ Yes ☐ No High ☐ Yes ☐ No *Details*	
Harm to others	Imminent ☐ Yes ☐ No High ☐ Yes ☐ No *Details*	
Other risks, incl family violence, absconding, vulnerabilities	☐ Yes *Details*	

Attach any relevant background information eg, discharge summaries, management plans, assessments

INTERNAL USE ONLY

Referral accepted	☐ Yes ☐ No	Outcome provided to referrer	☐ Yes ☐ No
Reason for non-acceptance			
Date referral accepted/declined			

Dec 2023
Source: AlfredHealth.org.au

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Last name*		First name/s*		Date of birth*	

Appendix A: Perinatal Stream

Child Name	DOB/ EDD if antenatal	Age	Sex	Breastfeeding
			☐ F ☐ M	☐ Y ☐ N
			☐ F ☐ M	☐ Y ☐ N
			☐ F ☐ M	☐ Y ☐ N
			☐ F ☐ M	☐ Y ☐ N

Name of child to be admitted	
Are there any concerns about the physical or mental health of the child to be admitted? Specify the gestational age at birth if the child was premature and if there is any ongoing active treatment required *eg. NG feeding*	☐ Yes *Details*
Does the child to be admitted co-sleep with the parent?	☐ Yes *Details*
Risk of harm to child / children	Imminent ☐ Yes ☐ No High ☐ Yes ☐ No *Details*
Comment on the consumer's ability to care for the child independently and/or what supports are currently required.	

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Last name*		First name/s*		Date of birth*	

Appendix B: Eating Disorders Stream

Diagnosis	☐ Anorexia nervosa ☐ Bulimia nervosa	☐ Avoidant/Restrictive Food Intake Disorder (ARFID) ☐ Other Specified Eating Disorder (OSFED)

Weight (kg)		**Height (cm)**		**BMI (kg/m^2)**		**Measurement date**	

Disordered Eating Behaviours	Provide details if present: frequency, duration, quantity
Oral restriction *(food and fluid)*	
Binge eating	
Purging/vomiting	
Laxative use	
Diuretic use	
Use of diet or weight loss medications *(eg. thyroxine/insulin)*	
Exercise	
Body image and body checking	
Preoccupation with weight / shape	
Other weight control behaviours	

Physical Assessment *(within 2 weeks of referral)*				
Date of Assessment				
Assessor Name and Role				
Blood Pressure	Lying		Standing	
Heart Rate	Lying		Standing	
Temperature		Random Blood Glucose Level		
Palpitations/chest pain	☐ Yes			
Syncope/fainting	☐ Yes			
Postural dizziness	☐ Yes			
Dyspnoea	☐ Yes			
Muscle weakness	☐ Yes			
Amenorrhoea	☐ Yes			
Investigations *(attached results)*	☐ Bloods		☐ Bone density / DEXA scan	
	☐ Weight / height trajectory chart		☐ ECG	
Inpatient medical admission within the last month?	☐ Yes *(list dates & facility)*			

If the consumer has had a recent inpatient medication admission outside of Alfred Health, attach		
☐ Food and fluid balance chart	☐ Meal plan / treatment from dietician	☐ Bowel Chart
☐ Medication chart	☐ Current MDT / care plans	☐ Sleep Chart
☐ Discharge Summary		

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