|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Referral details – Catheter Care** | | | | | | |
| **Service Requested** | **Catheter Assessment (once off – visit & report)**  **Catheter Changes (ongoing)**  **Intermittent Catheter assessment / education** | | | | | |
| **Referrer details** | Self / family  Health Care Professional  Support Coordinator  Other | | | | | |
| Your name: | | | | | |
| Email: | | | | | |
| Contact phone number: | | | | | |
| **Appointment preference** | Home Visit *(location dependent)*  Phone consult  Online eg Zoom | | | | | |
| **Person to contact to set up appointment** | Client  Family / Carer  Support Coordinator  Other / NOK | | | | | |
| **Client details** | | | | | | |
| **Client Name** |  | | | | | |
| **Date of Birth** |  | | | | | |
| **Address - Residential** |  | | | | | |
| **Address - Postal** | As above | | | | | |
| **Phone number** | (Home) | | | (Mobile) | | |
| **Email Address** |  | | | | | |
| **Medical Diagnosis** |  | | | | | |
| **Communication Preference** | SMS  Phone call  Email  Direct to: Client  NOK | | | | | |
| **Other Client Contacts – Family / NOK (if required)** | | | | | | |
| Name |  | | | | | |
| Relationship | Spouse Parent NOK  Advocate / Guardian | | | | | |
| Phone number |  | | | | | |
| Email Address |  | | | | | |
| **NDIS Participants** | | | | | | |
| **NDIS Plan details for the**  **Service Agreement**  *Estimated duration:*  ***Catheter Assessment 5hr*** *plus travel (if req’d), includes assessment, reporting and recommendations.*  ***Ongoing catheter changes*** *= tbc via SA, estimated 1hr+travel+consumables* | NDIS Reference Number | |  | | | |
| NDIA Managed – n/a (currently not available) | | Self Managed | | | Plan Managed |
| PM Company | |  | | | |
| Plan Dates | Start: | | | End: | |
| Email to send invoices to: (if known): | | | | | |
| We invoice under “Disability Related Health Supports – Nursing Supports”  Preference – use **Core Funding**  or **Capacity Building** | | | | | |
| **Person to send the Service Agreement to:** | Client  Spouse / Family / Carer  Support Coordinator  Advocate / Guardian  Other | | | | | |
| Email (if not already included above): | | | | | |
| **Any other information about the catheter care?** |  | | | | | |

Thank you for your referral – please complete & email back to [nurse@chaptersofcare.com.au](mailto:nurse@chaptersofcare.com.au)

We aim to reply within 1-2 business days to acknowledge the referral and commence the booking.