Health
Northern Sydney
Local Health District

## Assistive Technology & Seating NSLHD

Northern Sydney Local Health District ABN 63 834 171 987

**FAX ALL REFERRALS TO 9887 5048 Phone 9857 7200**

To facilitate progress of this referral, please provide as much information as possible.
It is recommended that the client's consent is obtained prior to making this referral.

**Client Name** First name ____________________ Date of Birth ____________

Family name ______________________________

**Client Address** ______________________________

______________________________ Post Code ________

Preferred Phone No ____________ Alternative ____________ Email ____________

**Diagnosis** Primary Secondary

**Eligibility** Referrals for clients with spinal injury are accepted for:
- Metropolitan clients who have specialist medical reviews at the Spinal Injury Unit RNSH, and
- Rural clients across NSW, except for those residing in the Illawarra region.

For clients with other diagnoses, referrals are accepted only from the hospitals and associated community health services shown below.

**Referral for clients with spinal cord injury** Spinal unit responsible for client's medical reviews:
❑RNSH ❑POWH ❑RR ❑None ❑Unknown (tick one option)

**Referral for clients of Northern Sydney Local Health District services**
Hospital or Community Health Service (tick): ❑RNSH ❑Manly ❑Mona Vale ❑Ryde ❑Hornsby Ku-ring-gai
❑Inpatient referral or ❑Community referral

Name of Ward/Service ____________________ For inpatients - expected discharge date ____________

Name of Ward/Service contact Phone / Pager

**Source of equipment funding**
❑Self funding ❑Enable NSW ❑Lifetime Care & Support ❑NDIS ❑Insurer ❑Other

Insurer details (Company name, contact name and phone, Case or claim number etc)

**Referrer** Name ____________________ Organisation ____________

Position ____________ Phone/Pager ____________ Fax ____________

Email ______________________________ Referral Date: ____________

**Will you review wheeled mobility access in the home and local community?** ❑ **Yes** ❑ **No**

**If 'No', please complete the following section.** Note that AT&S is generally unable to conduct access reviews in the home and community. If the referral is for a new wheelchair, a referral should also be made to a therapist (local to the client) for home and community access assessments, and follow up trials of equipment.

**Local Therapy Service**
Name of Organisation ____________________ Phone ____________

Therapist (if known) ____________________

Date referred to local service Expected waiting time for local service

**Please complete 'Reason for Referral' overleaf**

| **Client Name** | Date of Birth |
|---|---|

**Reason for referral and equipment type**

❑Power wheelchair ❑Manual wheelchair ❑Commode ❑Mattress/bed ❑Other

Concerns: Current or potential pressure areas (include location), problems with posture or function, device safety, need for review or replacement etc.

| **Current Equipment** (list brands & sizes) | **Manual chair** | **Motorised chair** |
|---|---|---|
| **Wheelchair** | | |
| | | |
| **Cushion** | | |
| | | |
| **Backrest** | | |

**Additional information** Please attach relevant photos and reports if available: client consent recommended.

Client Height (approx.) -

Client Weight (approx.) -

**Office use only**

Date received ______________________ Eligible for service Y / N Information complete Y / N

Date added to waiting list

Documents sent:

❑Referral Acknowledgment SD
❑Metro Service brochure SD
❑Rural Service brochure SD
❑Consent Forms
❑Rights and responsibilities brochure
❑Privacy Information for patients brochure
❑AT&S site map SD (metro or rural visiting Sydney)
❑Referral not accepted letter

Date Episode activated

Date Episode closed