FORM

KinCare

KinCare co-ordinated care program

Referring Hospital: **Date:**

Hospital Ward:	Phone:
Referral Name:	Fax:
Referrer Title:	Email:

Personal Information:

Client Name:	D.O.B:	Sex: ☐ M ☐ F
Address:		
Country of Birth:	Phone:	
Does the client have a carer or representative?	If yes, name:	
Relationship to client		
Address:		
Phone:	Email:	

Contacts:

GP Name:	GP Practice:
Fax/Email:	Tel No:
Emergency Contact Name:	Tick if same as carer/representative
Relationship:	Tel No:

Admission date:	
Reason for admission:	
Dementia diagnosis-Type	Date of diagnosis if known:
Geriatrician/Psychogeriatrician:	
Medication management: please circle	
• Independent/dosset box	Webster pack
• Carer assistance	Nursing assistance
Details…	
Does the client use medication to treat dementia? Yes/No	Medication name:
Relevant medical history:	
Community services currently in place/referrals pending:	
Reason for referral/further information:	
If transport home is required upon discharge	
Estimated discharge Date: _____/_____/_____ Requested Service Time: _____ am/pm	

Consent: Please indicate below if the client consents to their information being exchanged with other agencies to assist in the provision of services. ☐ Yes ☐ No