IMPORTANT

Australian Government
Department of Veterans' Affairs

Community Nursing Referral

Completing this form

This form can be used to refer a Department of Veterans' Affairs (DVA) client who requires Community Nursing services.

DVA will fund services delivered to eligible DVA Veteran Card (Gold Card or White Card) holders by an approved Community Nursing provider. White Card holders are entitled to receive DVA funded treatment for their **accepted** conditions only. White Card holders can also receive services under Non-Liability Health Care. For all Veteran White Card holders, the Community Nursing provider must contact DVA to determine eligibility to receive Community Nursing services for an assessed clinical nursing and/or personal care need prior to the commencement of Community Nursing services.

For details on DVA Community Nursing requirements please refer to the Notes for Community Nursing Providers available at https://www.dva.gov.au/providers/health-programs-and-services-our-clients/community-nursing-services-and-providers-0

Period of referral

General Practitioner (GP) Referral – Referrals are valid for 12 months, at which time a new referral is required.

Treating medical practitioner in a hospital or hospital discharge planner – The referral is valid for a period of six (6) weeks post discharge. An updated referral is required from the client's GP to cover ongoing care beyond the six (6) week period.

Nurse practitioner (specialising in Community Nursing field) – Referrals are valid for 12 months, at which time a new referral is required.

NOTE: The client's GP is to have ongoing clinical oversight of the person's care.

Submitting this form

Please send the referral directly to a DVA approved Community Nursing provider.

The Panel of DVA approved Community Nursing providers can be found on the DVA website at https://www.dva.gov.au/providers/health-programs-and-services-our-clients/community-nursing-services-and-providers/panel

DO NOT send this form to DVA.

PART A Referral type

1. Referral type

Community Nursing ☑

PART B Client Information

2. Client information

DVA file number

Card type

Gold ☐

White ☐ ▶ Please specify the accepted condition the service relates to

Title

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Surname

Given name(s)

Date of birth

Address

POSTCODE

Contact number [ ]

Specify type of accommodation

Note: If the client is a resident in a Residential Aged Care Facility they are ineligible to receive Community Nursing services.

☐ Private residence

☐ Independent Living Unit (ILU)

3. Medical condition(s)

4. Other health/support services

Is the client currently receiving any other health/support services?

No ☐

Yes ☐ ▶ Specify the services

☐ Veterans' Home Care (VHC)

☐ Coordinated Veterans' Care (CVC)

☐ Allied Health – please specify

☐ Other – please specify

5. My Aged Care

Has the client been assessed by the Aged Care Assessment Team/Service (ACAT/ACAS)?

No ☐ ▶ Please arrange for ACAT if the client is eligible.

Yes ☐ ▶ Specify approval types

- ☐ Residential Care
- ☐ Respite
- ☐ Commonwealth Home Support Programme (CHSP)
- ☐ Home Care Package (HCP)

Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4 ☐

Please describe services approved or being provided

PART C Referral to Provider details

6. Provider details

Provider name	**Commcare Health Services Pty Ltd**
Provider number (if known)	**97283241K**
Provider site	**Cranbourne East**
Contact number	[**61**] **403658750**
Contact email	**commcarehs@gmail.com**

7. Details of the Community Nursing services required for the client

e.g. wound care, personal care, medication management, etc.

8. Clinical details of the client's condition including recent illnesses, injuries and current medication, if applicable

Attach additional details (if applicable)

Note: If medication management is requested, then a signed Medication Authority/order must be attached.

9. Additional comments

PART D Referrer details

10. Referrer details

Referrer name

Referrer role/ position

Clinic/hospital name

Address

POSTCODE

Provider number

Contact number [ ]

Contact email

11. Declaration

I declare that the information I have supplied on this form and on any other attachments is true and correct.

Full name

Title

Signature
(electronic signature accepted)

Please note, no further changes can be made once form has been electronically signed.

Date

Community Nursing providers should retain this referral form for record keeping and Department of Veterans' Affairs audit purposes

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