Clinical Continence Services
General Referral Form

Date of Request:

Details of Person Requiring Service

First Name: **Surname:**

Date of Birth: **Gender:** **Preferred Pronouns:**

Home Address:

This address is *(Please tick)* ☐ Own/Family Home ☐ SDA/Supported Accommodation ☐ RAC/Nursing Home ☐ Other

Phone: **Email:**

Please note who these details are for if not for the person directly.

Referrer Details

Referrer name:

Relation to participant: *(Please tick)* ☐ Self ☐ Parent ☐ Next of Kin ☐ Support Coordinator ☐ Accommodation Service ☐ Legal Guardian/POA ☐ Advocate ☐ Other

Organisation:

Phone: **Email:**

Guardian/Nominee/Person Responsible

Guardian/Nominee/Person Responsible Name:

Relation to Person: *(Please tick)* ☐ Self ☐ Parent ☐ Next of Kin ☐ Support Coordinator ☐ Accommodation Service ☐ Legal Guardian/POA ☐ Advocate ☐ Other

Phone: **Email:**

Communication

Who is the best person to contact: *Please provide relationship and contact details if not already listed.*

How did you hear about our service: *(Please tick)* ☐ Word of mouth ☐ Internet ☐ Social Media ☐ Referred by other professional/service ☐ Promotion at expo/event ☐ Participant previously accessed service ☐ Other (please describe)

Is an interpreter required? ☐ Yes ☐ No If Yes, which language/dialect?

Aboriginal and Torres Strait Islander Identity:

☐ Neither Aboriginal nor Torres Strait Islander ☐ Aboriginal
☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander

GP Name/Contact Details:

Reason(s) for Referral *(Please tick)*

☐ Continence Assessment/Report ☐ Bedwetting ☐ Catheter Care
☐ Bladder Management ☐ Bowel Management ☐ Product Recommendations
☐ Nurse Provided Training (detail): ☐ Other/Details of request:

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Appointment Location Preference

☐ Telehealth (Video/Phone) ☐ Home/Community Visit

(We provide primarily telehealth services with limited face to face support in Melbourne and Sydney – we will let you know if we have capacity to meet your request for a home/community visit, or call us on ***1800 92 92 62*** *to discuss)*

Costs

Most services provided have costs associated. The services are provided as a non-profit, however we do not have government funding to provide individualized in-depth clinical services. As such, we charge the following rates:.

Agreed Supports	Hours Billed	Hourly Rate
Continence Assessment, Report & Prescription provided by a Nurse Continence Specialist (NCS). This may also include follow-up, liaison, ordering of samples and preparation of materials relevant to continence care. Most services provided by telehealth.	*Min 4 – up to 6 hours*	*$150 +GST (Min $660)*
Continence Training, Reviews & Health Supports provided by a NCS.	*Min 1 hour*	*$150 + GST*
Catheter Services	*Min 1 hour*	*$150 + GST*
Travel Fee if External Visit	*Billed as time taken*	*$150 + GST*

Please note, for NDIS participants (including paediatrics), please refer to our NDIS referral form, found on our website: *www.continence.org.au/ndis-continence-services*

For our Sydney Paediatric Clinic, please contact ***02 8741 5699****, or use the Paediatric Clinic form found here:* *www.continence.org.au/continence-foundation-australia-nsw-services*

Payment Details

Please select payment method:

☐ Home Care Package ☐ Privately Paying ☐ Another agency paying on my behalf

Invoice Details

Name:

Organisation (if applicable):

Email: **Phone:**

Continence Foundation of Australia

Phone: 1800 92 92 62
Email: clinical@continence.org.au
ABN: 84007325313

Melbourne Office:
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Surrey Hills, VIC 3127

Sydney Office:
6 Holker Street,
Newington, NSW, 2127