NSW GOVERNMENT | AGENCY FOR CLINICAL INNOVATION

# Referral to ACI Transition Service

**Date** Date **Referred by**

| **Hospital /Service name**<br>Enter Text | **Paediatric MRN**<br>Enter Text | **Adult MRN**<br>Enter Text | **Transition plan commenced?**<br>Enter Text |
|---|---|---|---|

| **Surname**<br>Surname | **First name**<br>Given Name | **Date of birth**<br>Date | **Gender**<br>Choose |
|---|---|---|---|

| **Address**<br>Address | **Aboriginal or Torres Strait Islander origin:**<br>YES ☐ NO ☐ N/A☐ |
|---|---|

**Medicare No:** Number

| **Home phone number:** Number | **Mobile number:** Number |
|---|---|

**Email address:** Email

| **Reliable Contact**<br>Name<br>**Relationship**<br>Family/Carer | **Address of other contact**<br>If different from above | **Phone number of other contact**<br>Contact number<br>**Email**<br>Email |
|---|---|---|

| **Interpreter required: YES ☐ NO ☐**<br>Language: Language | **Help required with communication: YES ☐ NO ☐**<br>Describe best communication method |
|---|---|
| **Primary diagnosis**<br>Enter text | **Co-morbidities (other medical conditions)**<br>Enter text |

**Priorities for management**
Enter text

**GP details:**
Enter text

**Education / employment status**
☐ School ☐ Preparing for Uni /TAFE ☐ TAFE/University ☐ Working - ☐ Full-time or ☐ Part-time ☐ Unemployed / Seeking Employment

**When do you want ACI to make contact with the young person/carer?** Enter text

**When is the young person's next and/or scheduled final paediatric appointment?** Please provide apt details

**Are there any potential transition barriers i.e. medications, equipment, procedures, infectious status etc.?** Enter text

**Has any information around transition been provided to the young person/carer? (I.e. factsheets etc.)** ☐ Yes ☐ No
**If yes, What has been provided? (In order to avoid duplication)** Enter text

| **PAEDIATRIC service details** | | | **ADULT service details** | | |
|---|---|---|---|---|---|
| **Name**<br>E.g. Dr. John SMITH | **Specialty**<br>Neurology | **Hospital/Service**<br>CHW | **Name**<br>Name | **Specialty**<br>Specialty | **Hospital/Service**<br>Enter Text |

**Recommended first appointment at adult service:**
Enter Text
**Date:** Enter Text
**Location:** Enter Text

**Consent:** I have discussed this referral with the young person and their carer and they agree to be contacted by the staff of the Transition Service. ☐