Repat Neuro-Behavioural Unit referral

In completing this referral, I acknowledge that I have read and understood the "Information for Referrers Sheet". The consumer I am referring has very severe to extreme behavioural and psychological symptoms of dementia (BPSD) which have not responded to appropriate specialised care plans in my service.

Please note this referral will not be actioned until we receive the required information. ALL sections must be completed. Please send through this referral to Repat NBU at email: Health.RepatNBU@sa.gov.au

---

Referrer details:

Name: ______________________________________ Role in Consumers care: ________________________________

Contact telephone number: _____________________________________

Treating Consultant Name (if not the referrer): ________________________ Referral date: __________________________

Consumer Information:

Name: _______________________________ Male/Female/Non-Binary: ___________________ DOB: ______________

Consumer MRN – if applicable ____________________________

Does your consumer identify as Aboriginal or Torres Strait Islander: Yes/No/Prefer not to answer.

Country of birth _________________________________

Preferred language and dialect ____

Home Address ____

____

Current location_____________________________ Admission date: _______________________________________

Next of Kin____

CONSENT: Referral has been discussed with guardian/SDM(s) and consent obtained Yes/No. If there is more than one guardian/ SDM, please note who gave consent:

____

____

Does the guardian/SDM(s) have a preferred location? If so, please indicate below.

Northgate ( ) **Repat NBU ( )** **Either ( )**

Will the guardian/SDM(s) consider either unit depending on where becomes available first?

Yes ( ) **No ( )**

Substitute decision maker(s) please attach all relevant orders to the referral

ACD ❏, EPOG ❏, Guardian ❏, MPOA ❏, EPOA ❏, Admin Order ❏, Other (eg interstate) ________________________________

HEALTHCARE:

Name(s):_________________________________ Relationship to consumer____________________________________

Contact details: ____

Date of expiration of Section 32(1)(a)/(b) AND (c) ______________________________ Is Order interim? Yes / No

FINANCIAL DECISIONS:

Name(s):____ Relationship to consumer: ____________________

Contact details: ____

Does the consumer have tenure / paying existing ongoing fees in a RACF? YES ❑ NO ❑

Critical Referral Information

Primary dementia diagnosis: ______________________________ When diagnosis made: ___________________________

Comorbid conditions: ____

Has a referral to the specialist dementia care unit (SDCU) been considered/completed? (If yes please provide DSA.report) ____

Is the consumer on any other facility/unit waitlists? ____

ALERTS including MRO status ____

Nature of any known trauma history Retained physical, functional and emotional abilities

BPSD indications

Vocalisation	Motor Agitation	Physical Aggression	Declining of Personal Care	Sexual disinhibition	Psychosis
❑ Infrequent ❑ Frequent Disruption level ❑ Nil ❑ Mild ❑ Moderate ❑ Severe	❑ Infrequent ❑ Frequent Severity level ❑ Nil ❑ Mild ❑ Moderate ❑ Severe	❑ Infrequent ❑ Frequent Severity level ❑ Nil ❑ Mild ❑ Moderate ❑ Severe	❑ Infrequent ❑ Frequent ❑ Bathing ❑ Toileting ❑ Dressing Number of staff needed to assist ……………………	❑ Infrequent ❑ Frequent ❑Severity ❑Nil ❑ Mild	❑ Infrequent ❑ Frequent Distress level ❑ Nil ❑ Mild ❑ Moderate ❑ Severe

Why does your consumer require care in an NBU level service?

What has been the impact of the identified BPSD indication(s) for the consumer, staff caring for them and what modifications have you made to the care environment to reduce this impact?

Please summarise what assessment and care interventions (non-pharmacological and pharmacological) have been trialled. Please attach additional page(s) if required.