



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

Provider number (if known)

Provider site

Contact number

Contact email

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.

