REFERRAL TO REMEDY HEALTHCARE

PHONE 1300 734 224 | FAX 1300 734 221

Please indicate if you would like to receive a **referral receipt** via: ☐ Fax ☐ Email ☐ Phone ☐ Not required

1. REFERRER DETAILS

Hospital:	
Referrer name:	Fax:
Phone:	Email:

2. PATIENT DETAILS

Name:		Next of kin:	
Address:		Next of kin phone:	
		Admission date:	Discharge date:
		Health Fund:	
		Membership or Claim No:	
DOB:	Phone:	BUPA ONLY Transfer Trim point:	DRG:

3. FUNDING

☐ Health fund ☐ Hospital ☐ Individual ☐ Home care package ☐ Aged care provider ☐ DVA No. ☐ TAC ☐ WorkCover

4. PROGRAM OR SERVICES REQUIRED

☐ **Hospital Care at Home** - Nursing, Physio, OT, Personal Care, Home Help, Meals	☐ **Mobility at Home** - Physiotherapy, Care Worker
☐ **Rehab at Home** - Nursing, Physio, OT, Personal Care, Home Help, Meals	☐ **Chronic Disease Management Program**
☐ **Allied Health** - Physio, OT, Podiatry, Dietitian (PHONE BASED)	☐ **Nursing care, education and support**

5. PATIENT'S MEDICAL DETAILS (THIS SECTION MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED)

Condition/Diagnosis/PHX:	ADL/Safety alerts:	
Allergies:	☐ Sufficient Family/Social support available to client at home	
☐ Hospital treating Doctor/Surgeon declares client medically stable		
Treating doctor/surgeon:	Phone:	Fax:
Usual GP:	Phone:	Fax:

6. SERVICE REQUIREMENTS (PLEASE COMPLETE ALL APPLICABLE FIELDS)

SERVICE TYPE	START DATE	FREQUENCY	DURATION days/wks	DESCRIBE CARE REQUIRED (include products/dressings required for nursing care)
☐ Nursing				
☐ Physiotherapy				
☐ Occup. Therapy				
☐ Personal Care				
☐ Home Help				
☐ Meals				
☐ Podiatry				
☐ Dietitian				

☐ Wound care chart to be provided & minimum 3 day's supply of products/dressings sent with patient

7. AUTHORISATION (THIS SECTION MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED)

If these services were not available, this patient would require additional hospital care OR inpatient rehabilitation for ☐ days.

Name:	Signature:	Date:
Role title:		

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