

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

<input type="checkbox"/> Hospital Care at Home - Nursing, Physio, OT, Personal Care, Home Help, Meals	<input type="checkbox"/> Mobility at Home - Physiotherapy, Care Worker
<input type="checkbox"/> Rehab at Home - Nursing, Physio, OT, Personal Care, Home Help, Meals	<input type="checkbox"/> Chronic Disease Management Program
<input type="checkbox"/> Allied Health - Physio, OT, Podiatry, Dietitian (PHONE BASED)	<input type="checkbox"/> 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:	<input type="checkbox"/> Sufficient Family/Social support available to client at home	
<input type="checkbox"/> 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)
<input type="checkbox"/> Nursing				
<input type="checkbox"/> Physiotherapy				
<input type="checkbox"/> Occup. Therapy				
<input type="checkbox"/> Personal Care				
<input type="checkbox"/> Home Help				
<input type="checkbox"/> Meals				
<input type="checkbox"/> Podiatry				
<input type="checkbox"/> Dietitian				
<input type="checkbox"/> 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:		

SUBMIT