Referral to Remedy Healthcare

Remedy HEALTHCARE IN YOUR HOME

Phone 1300 734 224 | Fax 1300 734 221 | Email getbetter@remedyhealthcare.com.au

Remedy always send a receipt of referral correspondence, if you don't receive this please call to check we have the referral.

1. Referrer and hospital details

Referrer (Please tell us about you)

First name

Last name

Role title

Work number

Email

Email (additional)

Hospital name

Hospital number

This number will be used to contact the patient or accounts team if we have an issue with financial eligibility.

2. Specialist and GP details

Treating specialist details

First name

Last name

Phone

Email

Fax (optional)

GPs details

First name

Last name

Phone

Email

Fax (optional)

3. Patient details

Please enter the patients details

First name

Last name

Date of birth dd mm yyyy

Sex ☐ Female ☐ Male ☐ Other/unspecified

Phone

Email

Address for discharge
(No PO Boxes)

Cultural / religious / language considerations (optional)

Name of health fund

Membership number

Hospital funded ☐ Yes

Next of Kin

First name

Last name

Relationship

Phone number

4. Patient's medical details

Admission date dd mm yyyy

Proposed DC date dd mm yyyy

Primary diagnosis and interventions / surgical procedures (if applicable)

PMHx

Current mobility / function / ADL's

Any complications during admission? ☐ Yes ☐ No

Details

Any known allergies? ☐ Yes ☐ No

Details

Social situation / supports ☐ Lives with others ☐ Lives alone ☐ Has a carer ☐ A carer for others

Social situation details (optional)

Any known infections? ☐ Yes ☐ No

Details

Any cognitive impairment/delirium? ☐ Yes ☐ No

Details

Any other community care services? ☐ Yes ☐ No

Details

On more than 5 medications? ☐ Yes ☐ No

Details

Any other wounds unrelated to this admission? ☐ Yes ☐ No

Details

SEE OVER TO COMPLETE FORM

Referral to Remedy Healthcare

Patient name:	
Patient DOB:	
Patient address:	

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5. Functional status (ONLY FOR REHABILITATION REFERRALS)

Patient goals

Previous functional status (mobility and ADLs)

Current functional status

Mobility ☐ Indep ☐ s/v ☐ 1 Assist ☐ 2 Assist ☐ Immobile

Distance meters

Transfers ☐ Indep ☐ s/v ☐ 1 Assist ☐ 2 Assist ☐ Immobile

Does the patient use a walking aid? ☐ Yes ☐ No

Walking aid type

Weight bearing restrictions ☐ Full ☐ Partial ☐ Touch ☐ WBAT ☐ Non-Weight bearing

Patient safe to manage stairs/steps? ☐ Yes ☐ No ☐ N/A

Patient has been assessed as a high falls risk? ☐ Yes ☐ No

Number of falls during current admission Fall/s

History of falls in the past 12 months? ☐ Yes ☐ No

History of fall details

Any precautions and/or contra-indication? ☐ Yes ☐ No

Precautions and/or contra-indication details

Any continence issues? ☐ Yes ☐ No

Select all continence issues ☐ Bladder ☐ Bowel

Toileting requirements ☐ Indep ☐ Supervision ☐ Assistance

Showering requirements ☐ Indep ☐ Supervision ☐ Assistance

Additional information

6. Service requirement details

Bed day savings by using home services

Patient from? ☐ Acute ward ☐ In patient rehab

☐ **Rehabilitation at Home - Multidisciplinary Program**

☐ Physiotherapy ☐ Occupational Therapy

☐ Rehab Nursing (Including wound review if required) ☐ Dietetics

☐ Personal Care ☐ Home Help ☐ Meals

☐ **Hospital Care at Home Program**

☐ Wound Management ☐ IV antibiotics/PICC Care

☐ NPWT/VAC ☐ Drain tube care ☐ Stoma/IDC/SPC care

☐ OT ☐ Physio ☐ Personal Care ☐ Meals ☐ Home Help

Service type	Start date	Sessions per week	Duration in weeks	Additional information e.g. Pharmacy contact details

7. Authorisation

☐ Hospital treating doctor/surgeon declares that the patient is medically stable, has suitable social support to safely engage in home-based care and is not being discharged against medical or allied health advice. The patient has consented to Remedy Healthcare disclosing their personal information to the health fund nominated in this form, or its authorised agent (as applicable), to ascertain funding eligibility, confirm receipt of relevant services and facilitate participation.

☐ I will send the patient home with 3 days of consumables for all Hospital care at home referrals.

Referrer name | Role title | Date

Signature

☐ I declare that the information provided by me in the referral is true and correct.

8. Referral checklists

Please provide the following documents Attach to email or fax the applicable documents to the fax number 1300 734 221

☐ I have attached specialist protocol (if applicable)

☐ I have included a wound care chart (if applicable)

☐ I have included a medication and PICC chart (if applicable)

☐ Hospital Care at Home checklist completed

Home visit staff safety checklist

History of aggression or violence? ☐ Yes ☐ No History of inappropriate behaviour? ☐ Yes ☐ No History of substance abuse? ☐ Yes ☐ No

Are there any other risks for home visiting? (behavioural/social issues, domestic violence, infectious diseases) ☐ Yes ☐ No

Precautions and/or contra-indication have been included in this referral? ☐ Yes ☐ No

SUBMIT VIA EMAIL