

IV Antibiotics Hospital Referral Checklist

Meets hospital substitution criteria for earlier discharge home from hospital



Check health fund financial eligibility



Referrals

Minimum standards to support safer, faster and better patient care:

- ✓ ALL sections of the referral form **MUST be completed for a referral to proceed**
- ✓ **Specialist name and contact details MUST be documented** as they maintain clinical governance throughout the program
- ✓ Diagnosis and relevant past medical history
- ✓ Signature on referral form - **a clinician MUST sign referral form**
- ✓ Bed day savings box **MUST be completed**
- ✓ Expected **length of program** to be documented on referral form

Refer early to enable Remedy to coordinate pharmacy & consumables.



IV Antibiotics

Complete ALL sections of the Medication Chart including PICC line details, dressing change date, Medical doctor contact details - **refer to highlighted areas.**

Document **PICC details** or send a copy of hospital PICC record (PICC length and when next dressing due required).

+24 hour infusers:

- ✓ Confirmation of the time the infuser was connected in hospital (pre discharge)
- ✓ Confirmation of the final infuser connection & PICC removal date

+Push or 60 minute infusions:

- ✓ Confirm time the last hospital dose administered



+Vancomycin:

- ✓ **Please call and discuss your referral**
- ✓ Confirm pathology company, contact number and days of the week pathology is due.
- ✓ Send Remedy a copy of all pathology slips provided to patient
- ✓ 2nd Dr contact name and details incase governing doctor is not available



Remedy will review documentation, gain approval from health fund, confirm service start date and arrange pharmacy and consumables – the hospital referrer will be notified when the case is approved.



Please do not discharge your patient home until Remedy provides service confirmation.



Discharge patient with first batch of infusers, X1 spare PICC line dressing, and **at least 3 days' worth of intravenous antibiotic consumables** (syringes and flushes).



Send referral to getbetter@remedyhealthcare.com.au or call 1300 734 224 to speak to nurse on triage



Remedy Healthcare Medication Chart can be found at www.remedyhealthcare.com.au



Please call & discuss urgent referrals



Please see over for form information

Get in touch


Call 1300 734 224 or email getbetter@remedyhealthcare.com.au to speak to nurse on triage

IV Antibiotics Hospital Referral Forms Guide

HEALTH FUND ELIGIBILITY LIST

Referring to Remedy Healthcare is simple

	Rehab@Home	Hospital Care@Home
Private Health Insurers	<ul style="list-style-type: none">• Hip & Knee• Replacement or revision	<ul style="list-style-type: none">• Other surgical/Medical• Reconditioning
ACA Health Benefits Fund	Yes	Yes
Australian Unity	Yes	Yes
BUPA	Yes	ONLY QLD - Call 1300 054 627
CBHS	Yes	Yes
Geelong District Health	Yes	Yes
CJA Health	Yes	Yes
Defence Health	Yes	Yes
DVA - Dept Vet Affairs	Not available	Call for options
Frank	Call for options	Call for options
GU Health	Yes	Yes
GRHBA	Call for options	Call for options
HCF	Yes	ONLY - IV AB/Complex wounds
Health Care Insurance	Yes	Yes
Health.com.au	Yes	Yes
Health Partners	Yes	Yes
HIP	Yes	Yes
LaTrobe Health Services	Yes	Yes
Mildura District Health	Yes	Yes
Navy Health	Yes	Yes
NIB	Call for options	Not available
OneMedifund	Yes	Yes
Peoplecare	Yes	Yes
PhoenixHealth	Yes	Yes
Police Health	Yes	Yes
Queensland Country Health	Yes	Yes
Reserve Bank Health Society	Yes	Yes
RT Health	Yes	Yes
St Lukes Health	Yes	Yes
Teachers Health (NTF)	Yes	Yes
Transport Health	Yes	Yes
Teachers Union Health	Yes	Yes
Nurses and Midwives Health	Yes	Yes
The Doctors Health Fund	Yes	Yes
Westfund Health Insurance	Yes	Yes

 To refer a patient to us
Download and complete our PDF referral form or use
our web form. If you need a hard call 1300 734 224
and our triage team will be happy to help.

Completed forms and supporting documentation can
also be emailed to getbetter@remedyhealthcare.com.au
or faxed to 1300 734 221. remedyhealthcare.com.au/refer

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REFERRAL FORM

Referral to Remedy Healthcare








Phone 1300 734 224 | Fax 1300 734 221 | Email getbetter@remedyhealthcare.com.au
Please indicate if you would like to receive a referral receipt via: ☐ Fax ☐ Email ☐ Phone ☐ Not required

1. REFERRER DETAILS	
Hospital:	Phone:
Referrer name:	Email:
<input type="checkbox"/> Pre-admission referral <input type="checkbox"/> Referral post hospital admission	DVA Provider No:
2. PATIENT DETAILS	
Name:	Next of kin:
Address:	Next of kin phone:
DOB:	Phone:
Email:	Mob:
DVA Card No:	Gold/White Card
Admission date:	Discharge date:
Health Fund:	Membership No:
FUNDING	
<input type="checkbox"/> Health fund <input type="checkbox"/> Hospital Funded <input type="checkbox"/> Self-funded <input type="checkbox"/> DVA <input type="checkbox"/> Home care package	
<input type="checkbox"/> NDIS <input type="checkbox"/> Compensation Body <input type="checkbox"/> TAC <input type="checkbox"/> Aged Care Provider <input type="checkbox"/> Other	
3. PROGRAM OR SERVICES REQUIRED	
<input type="checkbox"/> Hospital Care at Home <input type="checkbox"/> Rehabilitation at Home <input type="checkbox"/> DVA <input type="checkbox"/> Mobility at Home <input type="checkbox"/> Other	
Patient would otherwise stay in hospital for <input type="text"/> days	
4. PATIENT'S MEDICAL DETAILS (THIS SECTION MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED)	
Condition/Diagnosis/PHX:	ADL/Safety alerts:
<input type="checkbox"/> Hospital treating Doctor/Surgeon declares client medically stable	Allergies:
<input type="checkbox"/> Special surgeon protocols (please attach to referral)	RAPT score: <input type="checkbox"/> (mandatory for HCF referrals)
Treating doctor/surgeon:	Phone:
Usual GP:	Phone:
5. SERVICE REQUIREMENTS (PLEASE COMPLETE ALL APPLICABLE FIELDS)	
ALLIED HEALTH SERVICES	NURSING SERVICES
<input type="checkbox"/> Physiotherapy <input type="checkbox"/> Social Work (DVA only) <input type="checkbox"/> Wound Management <input type="checkbox"/> Medication Management	
<input type="checkbox"/> Podiatry <input type="checkbox"/> Exercise Physiology <input type="checkbox"/> IV Therapy/PICC Care <input type="checkbox"/> Pain Management	
<input type="checkbox"/> Dietician <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> NPWT/VAC <input type="checkbox"/> Drain Management	
<input type="checkbox"/> Personal Care <input type="checkbox"/> Meals <input type="checkbox"/> Home Help <input type="checkbox"/> Comprehensive Nursing A, <input type="checkbox"/> Comprehensive Nursing B	
<input type="checkbox"/> Wound care chart to be provided & minimum 3 day's supply of products/dressings sent with patient	
DESCRIBE CARE REQUIREMENTS	
Start Date:	Frequency:
Duration:	
6. AUTHORISATION (THIS SECTION MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED)	
Name:	Signature:
Role title:	Date:

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SUBMIT VIA EMAIL

MEDICATION CHART

Prescribed Medication Administration Chart		Phone: 1300 734 224 Fax: 1300 734 221 Email: getbetter@remedyhealthcare.com.au			
Patient details/label		Hospital Doctor maintaining Clinical Governance post discharge		Allergies and adverse drug reactions <input type="checkbox"/> Nil known <input checked="" type="checkbox"/> Known (Complete details below for known)	
Surname: Smith		Name: Dr Friendly		Medicine (or other allergen)	
Given names: John		Hospital switch 03 9400 0000		Reaction/date	
DOB: 01/01/1950		Page: 123		Sign	
Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F		Signature: 		Morphine	
Address: 123 Smiths Road, Melbourne		Authority to remove PICC Line (if known at time of referral):		Rash	
State: Victoria		Date of PICC line removal: 30/9/20			
Phone number: 03 9494 1234		Name: Dr Friendly			
Postcode: 3000		Signature: 			
		GP details			
		Name: Dr General Practitioner			
		Phone: 03 9876 5432			
Medication chart number 1 of 1		IV ACCESS DETAILS: <input checked="" type="checkbox"/> PICC <input type="checkbox"/> Cannula <input type="checkbox"/> Hickman's		Date inserted: 01/09/2020	
Hospital: Private Hospital		Date of last dressing: 8/9/20		Date of first hospital dose of IV antibiotics:	
Ward/Unit: Surgical ward #1		First dose of IV antibiotics administered in hospital without adverse event (tick): <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		PICC length (cm): 20cm from hub	
Phone: 03 9400 0000		Please tick requested infuser device: <input checked="" type="checkbox"/> Baxter infuser <input type="checkbox"/> Sapphire Pump		Arm circumference (cm) on d/c:	
Fax: 03 9400 1000		Ensure dose frequency indicates: 24 hour infusion/ Short Infusion (specify time required) / IV Push			
		Normal saline flush standing order: Doctor must sign for all IV medication orders to allow community nurse to administer IV push/flush.			
Date: 18/09/20		Dose: 13.5G		Date given	
Medicine (print generic name)		Piperacillin/Tazobactam		Time given	
Start Date: 19/9/20		Route: IV		Nurse Signature	
Cease Date: 29/9/20		Frequency: 24/24		Date given	
Doctors Name: Dr Friendly		Signature: 		Time given	
Doctors Signature: 				Nurse Signature	
Date: 18/09/20		Dose: 10mls		Date given	
Medicine: (Normal Saline)		0.9% Sodium Chloride for injection		Time given	
Start Date: 19/9/20		Route: IV		Nurse Signature	
Cease Date: 29/9/20		Frequency: daily		Date given	
Doctors Name: Dr Friendly		Signature: 		Time given	
Doctors Signature: 				Nurse Signature	

PLEASE ENSURE
HIGHLIGHTED
SECTION ARE
COMPLETED

Get in touch

Call 1300 734 224 or email getbetter@remedyhealthcare.com.au to speak to nurse on triage