

Rehabilitation @ Home Referral Guidelines

Meets Hospital Substitution Criteria – substitutes for an inpatient rehabilitation ward stay



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



Please do not discharge your patient home until Remedy has **confirmed approval and service capacity**.

Always refer early especially for clients who live in regional and remote areas



A physio discharge summary is required outlining clear **rehabilitation and/or reconditioning goals**



RAPT score is required for all HCF orthopaedic joint referrals



Date of surgeon review **MUST be documented**



Please list the clinical and non-clinical service requirements including **start date, frequency and duration of care**



OT discharge summary with **clear goals documented for reconditioning referrals** (if applicable)

Please arrange ongoing discharge plan for clients that may require longer term community nursing &/or personal care

If applicable **discharge patient home with consumables** to attend to dressing change or removal of staples/suture



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



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

Rehabilitation @ Home 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	<ul style="list-style-type: none">• Complex nursing care• IV antibiotics• Complex wounds• Drain care• Medication management• Pain management• Complex allied health
ACA Health Benefits Fund	Yes	Yes	Yes
Australian Unity	Yes	Yes	Yes
BUPA	Yes	Yes	ONLY OLD - Call 1300 054 627
CBHS	Yes	Yes	Yes
Cessnock District Health	Yes	Yes	Yes
CUA Health	Yes	Yes	Yes
Defence Health	Yes	Yes	Yes
DVA - Dept Vet Affairs	Not available	Not available	Call for options
Frank	Call for options	Call for options	Call for options
GU Health	Yes	Yes	Yes
GMHBA	Call for options	Call for options	Call for options
HCf	Yes	Not available	ONLY - IV AB/Complex wounds
Health Care Insurance	Yes	Yes	Yes
Health.com.au	Yes	Yes	Yes
Health Partners	Yes	Yes	Yes
HIF	Yes	Yes	Yes
LaTrobe Health Services	Yes	Yes	Yes
Mildura District Health	Yes	Yes	Yes
Navy Health	Yes	Yes	Yes
NIB	Call for options	Not available	Call for options
OneMedifund	Yes	Yes	Yes
Peoplecare	Yes	Yes	Yes
PhoenixHealth	Yes	Yes	Yes
Police Health	Yes	Yes	Yes
Queensland Country Health	Yes	Yes	Yes
Reserve Bank Health Society	Yes	Yes	Yes
RT Health	Yes	Yes	Yes
St Lukes Health	Yes	Yes	Yes
Teachers Health (NTF)	Yes	Yes	Yes
Transport Health	Yes	Yes	Yes
Teachers Union Health	Yes	Yes	Yes
Nurses and Midwives Health	Yes	Yes	Yes
The Doctors Health Fund	Yes	Yes	Yes
Westfund Health Insurance	Yes	Yes	Yes



To refer a patient to us

Download and complete our PDF referral form or use our web form. If you need a hand 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: Fax:
Referrer name:	Email:
<input type="checkbox"/> Preadmission 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"/> NDIS	<input type="checkbox"/> Compensation Body
<input type="checkbox"/> Self-funded	<input type="checkbox"/> TAC
<input type="checkbox"/> DVA	<input type="checkbox"/> Home care package
<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)	<input type="checkbox"/> Sufficient Family/Social support available to client at home
Treating doctor/surgeon:	Phone: Fax:
Usual GP:	Phone: Fax:
5. SERVICE REQUIREMENTS (PLEASE COMPLETE ALL APPLICABLE FIELDS)	
ALLIED HEALTH SERVICES	
<input type="checkbox"/> Physiotherapy	<input type="checkbox"/> Social Work (DVA only)
<input type="checkbox"/> Podiatry	<input type="checkbox"/> Exercise Physiology
<input type="checkbox"/> Dietitian	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Personal Care	<input type="checkbox"/> Meals
<input type="checkbox"/> Home Help	<input type="checkbox"/> Comprehensive Nursing A ₁
<input type="checkbox"/> Wound Management	
<input type="checkbox"/> IV Therapy/PICC Care	
<input type="checkbox"/> NPWT/VAC	
<input type="checkbox"/> Drain Management	
<input type="checkbox"/> Medication Management	
<input type="checkbox"/> Pain Management	
<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:
Date:	
Role title:	
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SUBMIT VIA EMAIL	



PLEASE ENSURE HIGHLIGHTED
SECTIONS ARE COMPLETED

Get in touch

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