

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:	Admission date:	Discharge date:
Email:	Mob:	Health Fund:	
DVA Card No:	Gold/White Card	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
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Patient would otherwise stay in hospital for 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:	RAPT score: <input type="text"/> (mandatory for HCF referrals)
<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		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"/> Dietitian	<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 _x
<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:		