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:	Phone:	Fax:
Referrer name:	Email:	
☐ Preadmission referral ☐ 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

☐ Health fund	☐ Hospital Funded	☐ Self-funded	☐ DVA	☐ Home care package
☐ NDIS	☐ Compensation Body	☐ TAC	☐ Aged Care Provider	☐ Other

3. PROGRAM OR SERVICES REQUIRED

☐ Hospital Care at Home	☐ Rehabilitation at Home	☐ DVA	☐ Mobility at Home	☐ Other

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:	
Allergies:	☐ Sufficient Family/Social support available to client at home	
☐ Hospital treating Doctor/Surgeon declares client medically stable		
Treating doctor/surgeon:	Phone:	Fax:
Usual GP:	Phone:	Fax:

5. SERVICE REQUIREMENTS (PLEASE COMPLETE ALL APPLICABLE FIELDS)

ALLIED HEALTH SERVICES		NURSING SERVICES	
☐ Physiotherapy	☐ Social Work (DVA only)	☐ Wound Management	☐ Medication Management
☐ Podiatry	☐ Exercise Physiology	☐ IV Therapy/PICC Care	☐ Pain Management
☐ Dietitian	☐ Occupational Therapy	☐ NPWT/VAC	☐ Palliative Care
☐ Personal Care ☐ Meals ☐ Home Help		☐ Comprehensive Nursing A_x	☐ Drain Management

☐ 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