Metropolitan referral unit - referral form

Government of South Australia
SA Health

Health Care @ Home (HC@H), Country Home Link (CHL)
Please complete form and fax to 8201 7822 or phone 1300 110 600

Referral source ☐ Public hospital ☐ Mental Health ☐ GP ☐ Aged care facility ☐ Other

PATIENT INFO Sticker/MR10/UR No: _____

Surname: _____ First name: _____

Address: _____

Suburb: _____

_____ P/Code: _____

Address where care to be provided (if not usual address)

Address: _____

Suburb: _____

☐ Male ☐ Female DOB: ___/___/___

Telephone: _____

Mobile: _____

NOK: _____

Relationship: _____ Telephone: _____

Allergies: _____

DATE OF REFERRAL: ___/___/___ TIME: _____

Referring hospital/agency: _____

Admission date: ___/___/___ Discharge date: ___/___/___

Ward/Unit: _____ Ext no: _____

Referrer's name: _____

Requested commencement date: ___/___/___

General Practitioner: _____

Telephone: _____

ACAT: ☐ No ☐ Yes high ☐ Yes low ☐ Referred

DVA Card: ☐ No ☐ Yes, number: _____

Country of birth: ☐ Australia Other: _____

Interpreter required? ☐ No ☐ Yes, type: _____

Health fund: ☐ No ☐ Yes, fund name: _____

Membership no: _____

☐ MRSA ☐ VRE Other: _____

Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown

Usual living arrangements: ☐ Alone ☐ With parent/carer/legal guardian ☐ With spouse ☐ Homeless ☐ Independent living unit

Aged care facility: ☐ Low level ☐ High level

Known hazards/alerts (eg animals, aggression): _____

Other relevant information: _____

PRIMARY DIAGNOSIS ☐ Mental health (please attach MH referral form)

_____

_____

Secondary conditions (including mental health): _____

Past history: _____

_____

_____

CURRENT COMMUNITY SERVICES (include name of provider and phone number):	**CURRENT CARE PROVIDED**

MANAGEMENT PLAN/CARE REQUESTED:

_____

_____

_____

_____

_____

Attached: ☐ Medication authority ☐ Mental health referral ☐ Risk assessment ☐ EOLC additional information

Equipment in place: _____

Requested: _____

NEW SERVICES ARRANGED ON DISCHARGE includes long term services arranged for post package

PROVIDER NAME	SERVICE REQUESTED	CONTACT No.	START DATE

Referrer's signature: _____ Position: _____

Contact details: _____ Date and time faxed: _____

OFFICE USE ONLY

☐ A1 ☐ A2 ☐ A3 ☐ B1 ☐ B2 ☐ B3 ☐ CR1 ☐ CR2 ☐ CR3 ☐ CC1 ☐ CC2 ☐ CC3
☐ D1 ☐ D2 ☐ D3 ☐ E2 ☐ E3 ☐ F1 ☐ F2 ☐ F3 ☐ G1 ☐ G2 ☐ G3 ☐ H1 ☐ H3
☐ I ☐ JS ☐ JI ☐ K2 ☐ K3 ☐ LE1 ☐ LC1 ☐ LR2 ☐ LE3 ☐ LC3 ☐ LR3 ☐ M1 ☐ M2
☐ M3 ☐ N-CW ☐ EN ☐ RN1 ☐ RN2 ☐ CPC ☐ PT ☐ OT ☐ SP ☐ SW ☐ DT ☐ SAFT ☐ INT