



DOB _____	PID Number
Gender _____	
Title _____ Surname _____	
Given Names _____	
Address _____	
<i>(Type or affix sticker)</i>	

Home Hospital – Referral Request

AVAILABLE 24 HOURS A DAY 7 DAYS A WEEK

**Complete and Fax to 1300 601 788 Please fax all referrals individually
Telephone (08) 9242 0347 to provide full clinical handover to Liaison Nurse for eligibility
for service.**

DO NOT WRITE IN THIS BINDING MARGIN
All clinical forms creation and amendments must be conducted through the documentation control process

Home Hospital – Referral Request

CLIENT DETAILS (attach label if applicable)		1 st Visit Date:
Full Name:		1 st Visit Time: AM / PM
Address:		
Telephone:	Date of Birth:	
Email:		
Medicare Number:	URN:	
Next of Kin/Carer Name:	NOK Telephone:	
Relevant Medical, Surgical and Social History		
REFERRAL DETAILS		
Diagnosis:		Date:
Treatment/Care Plan (Treatment, Expected Duration and Follow-up Required)		
Has the first dose been given? <input type="checkbox"/> Yes <input type="checkbox"/> No		Time Given:
Is the Client on Warfarin? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dosage in mg (last given):
PICC Line Details: Type		
External Length:		Certified to Use: <input type="checkbox"/> Yes <input type="checkbox"/> No
MEDICAL PRACTITIONERS		
Consultant Name:		Contact Number:
Doctor Responsible for Medical Governance:		
Contact Number (24/7):		
Current GP Details: Name:		Telephone:



DOB _____	PID Number _____
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<i>(Type or affix sticker)</i>	

Home Hospital – Referral Request

REFERRER DETAILS (Person completing the form)	
Name: _____	Hospital: _____
Telephone: _____	Ward: _____

CLIENT DETAILS - MUST be completed on this page for medications to be administered (attach client label above OR provide 3 identifiers)	
Full Name: _____	Date of Birth: _____
Address: _____	

ALLERGIES

MEDICATIONS

Date	Medication (Please Print)	Time																	
	Tick if variable dose <input type="checkbox"/>																		
Route	Dose	Frequency	Time																

Prescriber Signature: _____	Print Name: _____	Prescriber No: _____
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Date	Medication (Please Print)	Time																	
	Tick if variable dose <input type="checkbox"/>																		
Route	Dose	Frequency	Time																

Prescriber Signature: _____	Print Name: _____	Prescriber No: _____
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Date	Medication (Please Print)	Time																	
	Tick if variable dose <input type="checkbox"/>																		
Route	Dose	Frequency	Time																

Prescriber Signature: _____	Print Name: _____	Prescriber No: _____
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