

Remedy always send a receipt of referral correspondence, if you don't receive this please call to check we have the referral.

1. Referrer and hospital details

Referrer (Please tell us about you)

First name	<input type="text"/>
Last name	<input type="text"/>
Role title	<input type="text"/>
Work number	<input type="text"/>

Email	<input type="text"/>
Email (additional)	<input type="text"/>
Hospital name	<input type="text"/>
Hospital number	<input type="text"/>

This number will be used to contact the patient or accounts team if we have an issue with financial eligibility.

2. Specialist and GP details

Treating specialist details

First name	<input type="text"/>
Last name	<input type="text"/>
Phone	<input type="text"/>
Email	<input type="text"/>
Fax (optional)	<input type="text"/>

GPs details

First name	<input type="text"/>
Last name	<input type="text"/>
Phone	<input type="text"/>
Email	<input type="text"/>
Fax (optional)	<input type="text"/>

3. Patient details

Please enter the patients details

First name	<input type="text"/>
Last name	<input type="text"/>
Date of birth	<input type="text" value="dd"/> <input type="text" value="mm"/> <input type="text" value="yyyy"/>
Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other/unspecified
Phone	<input type="text"/>
Email	<input type="text"/>
Address for discharge (No PO Boxes)	<input type="text"/>

Cultural / religious / language considerations (optional)	<input type="text"/>
Name of health fund	<input type="text"/>
Membership number	<input type="text"/>
Hospital funded	<input type="checkbox"/> Yes

Next of Kin

First name	<input type="text"/>
Last name	<input type="text"/>
Relationship	<input type="text"/>
Phone number	<input type="text"/>

4. Patient's medical details

Admission date	<input type="text" value="dd"/> <input type="text" value="mm"/> <input type="text" value="yyyy"/>
Proposed DC date	<input type="text" value="dd"/> <input type="text" value="mm"/> <input type="text" value="yyyy"/>
Primary diagnosis and interventions / surgical procedures (if applicable)	<input type="text"/>
Any complications during admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details	<input type="text"/>
Any known allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details	<input type="text"/>
Social situation / supports	<input type="checkbox"/> Lives with others <input type="checkbox"/> Lives alone <input type="checkbox"/> Has a carer <input type="checkbox"/> A carer for others
Social situation details (optional)	<input type="text"/>

PMHx	<input type="text"/>
Current mobility / function / ADL's	<input type="text"/>
Any known infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details	<input type="text"/>
Any cognitive impairment/delirium?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details	<input type="text"/>
Any other community care services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details	<input type="text"/>
On more than 5 medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details	<input type="text"/>
Any other wounds unrelated to this admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details	<input type="text"/>

Referral to Remedy Healthcare

Phone 1300 734 224 | Fax 1300 734 221 | Email getbetter@remedyhealthcare.com.au

Patient name:
Patient DOB:
Patient address:

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5. Functional status (ONLY FOR REHABILITATION REFERRALS)

Patient goals		Patient safe to manage stairs/steps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Previous functional status (mobility and ADLs)		Patient has been assessed as a high falls risk?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Current functional status		Number of falls during current admission			Fall/s
		History of falls in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
		History of fall details			
		Any precautions and/or contra-indication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
		Precautions and/or contra-indication details			
		Any continence issues?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
		Select all continence issues	<input type="checkbox"/> Bladder	<input type="checkbox"/> Bowel	
Does the patient use a walking aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toileting requirements	<input type="checkbox"/> Indep	<input type="checkbox"/> Supervision	<input type="checkbox"/> Assistance
Walking aid type		Showering requirements	<input type="checkbox"/> Indep	<input type="checkbox"/> Supervision	<input type="checkbox"/> Assistance
Weight bearing restrictions	<input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Touch <input type="checkbox"/> WBAT <input type="checkbox"/> Non-Weight bearing	Additional information			

6. Service requirement details

Bed day savings by using home services		Patient from?	<input type="checkbox"/> Acute ward	<input type="checkbox"/> In patient rehab			
<input type="checkbox"/> Rehabilitation at Home - Multidisciplinary Program		<input type="checkbox"/> Hospital Care at Home Program					
<input type="checkbox"/> Physiotherapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Wound Management	<input type="checkbox"/> IV antibiotics/PICC care				
<input type="checkbox"/> Rehab Nursing (Including wound review if required)	<input type="checkbox"/> Dietetics	<input type="checkbox"/> NPWT/VAC	<input type="checkbox"/> Drain tube care	<input type="checkbox"/> Stoma/IDC/SPC care			
<input type="checkbox"/> Personal Care	<input type="checkbox"/> Home Help	<input type="checkbox"/> Meals	<input type="checkbox"/> OT	<input type="checkbox"/> Physio	<input type="checkbox"/> Personal Care	<input type="checkbox"/> Meals	<input type="checkbox"/> Home Help

Service type	Start date	Sessions per week	Duration in weeks	Additional information e.g. Pharmacy contact details

7. Authorisation

Hospital treating doctor/surgeon declares that the patient is medically stable, has suitable social support to safely engage in home-based care and is not being discharged against medical or allied health advice. The patient has consented to Remedy Healthcare disclosing their personal information to the health fund nominated in this form, or its authorised agent (as applicable), to ascertain funding eligibility, confirm receipt of relevant services and facilitate participation.

I will send the patient home with 3 days of consumables for all Hospital care at home referrals.

Referrer name		Role title		Date	
Signature		<input type="checkbox"/> I declare that the information provided by me in the referral is true and correct.			

8. Referral checklists

Please provide the following documents Attach to email or fax the applicable documents to the fax number 1300 734 221

- I have attached specialist protocol (if applicable)
- I have included a medication and PICC chart (if applicable)
- I have included a wound care chart (if applicable)
- Hospital Care at Home checklist completed

Home visit staff safety checklist

- History of aggression or violence? Yes No
- History of inappropriate behaviour? Yes No
- History of substance abuse? Yes No
- Are there any other risks for home visiting? (behavioural/social issues, domestic violence, infectious diseases) Yes No
- Precautions and/or contra-indication have been included in this referral? Yes No