REFFERAL TO VITALIS COMPLEX CLINICAL CARE AT HOME

PHONE 0450 435 892 | FAX 02 8540 3812 | EMAIL complex@vitalis.health

Please indicate if you would like to receive a **referral receipt** via: Fax | Email | Phone | Not required

REFERRER DETAILS	
Hospital/ Organisation:	
Referrer Name:	Fax:
Phone:	Email:

PATIENT DETAILS		
Name:		Next of Kin:
Address:		Next of Kin phone:
		Admission Date:
		Discharge Date:
		Health Fund:
DOB:	Phone:	Membership or Claim No:
NDIS Membership Number (if applicable):		Medicare No:

FUNDING			
Health Fund	Hospital	Individual/ Private	WorkCover
NDIS (Please attach proof of approved funding to this form)	NDIS Approved Funding: RN EN High Intensity Level 3 High Intensity Level 2 Carer Other: (specify)___________________________________		

PROGRAM OR SERVICES REQUIRED	
Complex Clinical Care	How many hours of care per day required/approved? 28 hours 24 hours Less than 24 hours (specify): ______________________________

PATIENT'S MEDICAL DETAILS (THIS SECTION MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED)		
Condition/Diagnosis/PHX:	ADL/Safety Alerts:	
Allergies:		
Hospital treating Doctor/Surgeon declares client medically stable	Sufficient Family/Social support available to client at home	
Treating doctor/surgeon:	Phone:	Fax:
Usual GP:	Phone:	Fax:

SERVICE REQUIREMENTS				
SERVICE TYPE	START DATE	FREQUENCY	DURATION days/weeks	DESCRIBE CARE REQUIRED (include products/dressings required for nursing care)
Nursing				
Physiotherapy				
Occup. Therapy				
Personal Care				
Home Help				
Meals				
Podiatry				
Dietitian				
Wound care chart to be provided if relevant				

AUTHORISATION (THIS SECTION MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED)		
Name:	Role title:	Date:
Signature:		