REFERRAL TO VITALIS HOSPITAL IN THE HOME

PHONE 0451 439 322 | FAX 02 8540 3812| EMAIL hith@vitalis.health

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

PATIENT DETAILS

Name:		Next of kin name:
Address on discharge:		Relationship:
		Next of kin phone:
		Hospital admission date:
		Planned hospital discharge date:
☐ Home Address	☐ Other _____	Requested date of 1st Vitalis visit:
DOB:	Phone:	Health Fund:
Email:		Membership or Claim No:
		Medicare No:

REFERRER DETAILS

Hospital:	
Referrer name:	Fax:
Ward Phone:	Email:

FUNDING

☐ Health Fund: _____	☐ Hospital	☐ NDIS	☐ Other _____
☐ Aged Care Provider:_____	☐ Individual/Private	☐ WorkCover	☐ Homecare package

PROGRAM OR SERVICES REQUIRED

☐ Hospital in the Home	☐ Palliative Care in the Home
☐ Home Care	☐ Infusion Therapy in the Home
☐ Chemo/immunotherapy in the Home	☐ Other _____

PATIENT'S MEDICAL DETAILS

Condition/Diagnosis/Current Issues:	Safety alert/Infection risks:	
	Social support/Living circumstances:	
PMHx:		
	☐ Treating consultant declares client medically stable for hospital discharge to Vitalis home services	
Allergies:		
Treating doctor/surgeon:	Phone:	Fax:
Usual GP:	Phone:	Fax:

CLINICAL/SERVICE REQUIREMENTS

SERVICE TYPE

☐ **IV Therapy**

Medication(s):	Dose(s):
Frequency of infusion:	☐ 24 hour Baxter Infusor
Duration of therapy:	Start date of IV therapy in hospital:
	Cease date and PICC removal:

Note: If patient requires **oral antibiotic therapy** following IV treatment, where possible, the treating consultant should provide patient with a hardcopy prescription prior to discharge from hospital

Attached: Dr referral letter ☐ Medchart ☐ PICC insertion record ☐ Most recent bloods/serum abx level ☐

Vitalis will arrange Baxter Infusors and VAC consumables

☐ **VAC Negative Pressure Therapy or Complex Wound Care (>0.5cm in depth)**

Description of wound and aetiology:	Dressing products: ACTIV.A.C. ☐ SNAP VAC ☐
	Wound dressing type:
Length: Width: Depth:	Dressing frequency:

Attached: ☐ Wound care chart ☐ Images

☐ Where applicable, minimum 3 day/s supply of products/dressings sent with patient

Vitalis will arrange Baxter Infusors and VAC consumables

Declaration: The patient would otherwise stay in hospital ___ **days** (please complete) without home services

AUTHORISATION

Name:	Signature:
Date:	Role title:

All relevant sections of this form must be complete in order to process the referral. Vitalis accepts no responsibility for inaccurate information communicated to us.