REFERRAL TO VITALIS – REHABILITATION IN THE HOME (RITH)

PHONE 0405 069 234 | FAX 02 8540 3812 | EMAIL RITH@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	☐ Home Care Package

PROGRAM OR SERVICES REQUIRED *please call to discuss appropriate tier*	
☐ Rehabilitation in the Home – Tier One (RAPT score <6 or 6-7)	☐ Other services - please specify:
☐ Rehabilitation in the Home – Tier Two (RAPT score 6-9)	-
☐ Rehabilitation in the Home – Tier Three (RAPT score 8-12)	-

PATIENT'S MEDICAL DETAILS		
Primary diagnosis/surgical procedure/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:

REFERRAL INFORMATION
Attached: ☐ Dr referral letter
Attached: ☐ Discharge summary
Attached: ☐ RAPT score (if applicable)
Attached: ☐ Dr specific instructions (if any)

DECLARATION
The patient would otherwise stay in hospital for _____ (please complete) days 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.