REFFERAL TO VITALIS COMPLEX CLINICAL CARE AT HOME

PHONE 0450 435 892 | FAX 02 9191 0211 | 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:		