



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 first 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			
<input type="checkbox"/> Hospital in the Home		<input type="checkbox"/> Palliative Care in the Home	
<input type="checkbox"/> Home Care		<input type="checkbox"/> Infusion Therapy in the Home	
<input type="checkbox"/> Chemo/immunotherapy in the Home		<input type="checkbox"/> 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			
IV Therapy			
Medication(s):		Dose(s):	
Frequency of infusion:		24 hour Baxter Infusor	
Duration of therapy:		Start date of IV therapy in hospital:	
Planned date of final dose:		Cease date and PICC removal:	
Aminoglycosides (Gentamicin; Tobramycin; Amikacin): If course is longer than three doses, confirm with ID physician whether baseline audiometry is needed.			
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 <input type="checkbox"/> Medchart <input type="checkbox"/> PICC insertion record <input type="checkbox"/> Most recent bloods/serum abx level <input type="checkbox"/> Audiometry <input type="checkbox"/>			
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. <input type="checkbox"/> SNAP VAC <input type="checkbox"/>	
		Wound dressing type:	
Length:	Width:	Depth:	
		Dressing frequency:	
Attached: Wound care chart <input type="checkbox"/> Images <input type="checkbox"/> 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.