Swan Hill District Health

HOSPITAL IN THE HOME REFERRAL

UR: | | | | | | |

Surname: .....

Given Name: .....

DOB: ..... / ..... / .....

"Place Patient Label Here"

*Referrer: Please complete this form and fax to SHDH HITH (**5033 9398**) or email to **dns@shdh.org.au** & cc:**BetteratHome@shdh.org.au***

Client Details

HITH RN _____ contacted for client handover. Date ____/____/____ Time: _____

Interpreter Required: ☐ No ☐ Yes Language spoken at Home:_____

Preferred name: _____ Client / Carer aware of referral ☐ No ☐ Yes

Client can be contacted on Phone/Mobile: _____

Next of kin / contact _____	GP Name _____
Relationship _____	GP Address _____
Phone _____	Phone _____

Diagnosis / reason for visit _____

_____

Relevant past history _____

_____

Allergies _____

_____

Services Required:

☐ Nursing	☐ Speech Pathology	☐ Hygiene assistance
☐ Physiotherapy	☐ Dietetics	☐ Meals
☐ Occupational Therapy	☐ Social Work	☐ Other (Please specify below)
☐ Podiatry	☐ Pharmacy	

Additional Information: Specific Details, e.g. Antibiotic dose and frequency, IV access type/location/size/date, wound regimen, catheter type/size.

Relevant Information

Mobility _____

Cognitive status _____

Continence _____

Client/safety issues _____

Other_____

_____

Attachment Requirements

Documents required to be attached for referral consideration.

☐ **Medication chart** ☐ **Observation Chart**

☐ **Draft Discharge Summary** ☐ **Pathology**

If Applicable:

☐ **PICC insertion documentation** ☐ **Wound chart attached**

☐ **Other (specify)** _____

Referrer Details

Hospital/Clinic _____

Phone _____ Fax _____ Planned discharge date _____/_____/_____

First visit HITH requested _____/_____/_____

Referrer Name (please print) & Designation:_____

Signature _____ Date _____/_____/_____

HOSPITAL IN THE HOME REFERRAL MR79A