

REFERRAL FOR ADMISSION	
Phone: 9595 3424 Fax: 9596 0126	
For Patients: give this form to your doctor to refer you to Calvary Bethlehem	
For Doctors: use this form for patient referrals to Calvary Bethlehem	
Referred by:	
Name:	Designation:
Organisation:	Phone:
	Fax:
Sign:	Date:
Doctor's Provider No:	
Referral designation: (please tick correct box) <input type="checkbox"/> Terminal care <input type="checkbox"/> Assessment <input type="checkbox"/> Symptom management <input type="checkbox"/> Maintenance <input type="checkbox"/> Inpatient Admission <input type="checkbox"/> Community Palliative Care Service (CPCS) <input type="checkbox"/> Neurological Ambulatory Service (NAS) Does the patient have an existing advanced care plan/ advanced care directive or goals of care document? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, pleas attach a copy.	
Reason for referral / Current issues: <hr/> <hr/> <hr/> <hr/> <hr/> Please provide more information: <hr/> <hr/> <hr/> <hr/>	
Patient and family expectations: <hr/> <hr/> <hr/> <hr/>	



Patient details:					
Title	First name:			Surname:	
Address:			Service address:		
Marital status:	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced/Separated	<input type="checkbox"/> Single	<input type="checkbox"/> Partner
Country of birth:					
Patient's phone numbers:					
Home:		Mobile:		Work:	
Preferred contact person:					
Preferred mode of contact:		<input type="checkbox"/> Mail	<input type="checkbox"/> Phone	<input type="checkbox"/> Email: _____	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other	DOB:	Age:	Religion:
Preferred language:		Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No		ATSI <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family/Carer details:					
Next of Kin:			Relationship to Patient:		
Phone numbers:			Lives with Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Social situation:		<input type="checkbox"/> Lives alone	<input type="checkbox"/> Carer	<input type="checkbox"/> Residential care <input type="checkbox"/> Low level care <input type="checkbox"/> High level care	

Service providers:	
GP name:	Address:
Phone no:	Fax no:
Specialist name:	Address:
Phone no:	Fax no:
Other service providers:	

Clinical information:

Diagnosis:

Accompanying Documentation (e.g. medical letters, discharge investigations etc):

Allergies:

Behavioural or cognitive concerns:

Signed:	Designation:
Date:	

