CALVARY HEALTH CARE BETHLEHEM

REFERRAL FOR ADMISSION

Phone: 9595 3424 **Fax: 9596 0126**

Referrer's Details	
Name:	Designation:
Organisation:	Phone:
	Fax:
Sign:	Date of referral:
Doctor's Provider Number:	

Referral Designation (please tick the correct box below)

Terminal Care ☐ Assessment ☐ Symptom Management ☐ Maintenance ☐

Inpatient Admission ☐ Community Palliative Care Service (CPCS) ☐

Statewide Progressive Neurological Diseases Service (SPNDS) ☐

Does the patient have an existing advance care plan / advance care directive or goals of care document?

Yes ☐ If Yes, please attach a copy to this document No ☐

Reason for referral / Current issues

Please include any information which may be useful as background information to assist with the referral

Patient and family expectations:

REFERRAL FOR ADMISSION

MR 015

Version 1, Ratified February 2019

Patient Details				
Title:	First Name:		Surname:	
Address:				
Home phone:	Mobile:		Email:	
Preferred mode of contact: Mail ☐ Phone ☐ Email ☐				
Male ☐ Female ☐ Other ☐	DOB:	Age:	Religion:	
Married / partner ☐	Widowed ☐	Divorced / Separated ☐	Single ☐	
Country of birth:	Preferred language:		Interpreter needed: Y / N	
Aboriginal or Torres Strait Islander: Yes ☐ No ☐				
Medicare no:		Medicare Reference no:		
Private Health Fund:		Health fund no:		
Preferred Contact person:				
Patient's social situation:	☐ Lives alone			
	☐ Lives with carer			
	☐ Residential Care Low Level care ☐ High Level Care ☐			

Family / Carer Details	
Name of Social Contact / Emergency Contact / Carer:	
Relationship to patient:	Home phone:
	Mobile number:
Lives with patient? Yes ☐ No ☐	

Service Providers	
GP Name:	Address:
Phone no:	Fax:
Specialist's name:	Address:
Phone no:	Fax:
Other service providers:	

Clinical Information:
Diagnosis:
Accompanying Documentation (e.g. medical letters, discharge, investigations etc):
Allergies:
Behavioural or cognitive concerns:

Signed:	Name:
Designation:	Date: