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:

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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:	

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

Signed:	Name:
Designation:	Date: