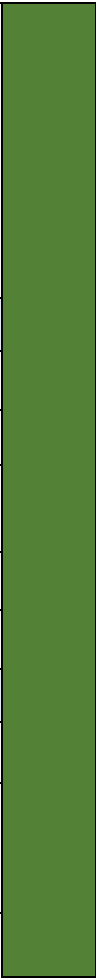


<p style="text-align: center;">CALVARY HEALTH CARE BETHLEHEM</p> <p style="text-align: center;">REFERRAL FOR ADMISSION</p> <p>Phone: 9595 3424 Fax: 9596 0126</p>		<p>Email to:</p> <p>BET-Access&Intake@calvarycare.org.au</p>
Referrer's Details		
Name:		Designation:
Organisation:		Phone:
		Fax:
Sign:		Date of referral:
Doctor's Provider Number:		
Referral Designation (please tick the correct box below)		
Terminal Care <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"/>		
Statewide Progressive Neurological Diseases Service (SPNDS) <input type="checkbox"/>		
Does the patient have an existing advance care plan / advance care directive or goals of care document? Yes <input type="checkbox"/> If Yes, please attach a copy to this document No <input type="checkbox"/>		
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

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