CALVARY HEALTH CARE BETHLEHEM REFERRAL FOR ADMISSION **Phone: 9595 3424** **Fax: 9596 0126**	**Email to:** **BET-Access&Intake@calvarycare.org.au**

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:	

Version 1, Ratified February 2019

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

Signed:	Name:
Designation:	Date: