

Hospital Care at Home Referral

referral@ramsayhomehealth.com.au | 1800 799 732

1.

PATIENT DETAILS

First Name:	Last Name:	
Date of Birth:	Gender:	
Address for discharge:		
State:	Postcode:	
Phone number:	Email:	
Cultural/language considerations?		
Is the patient of Aboriginal and/or Torres Strait Islander origin?	Aboriginal origin Torres Strait Islander origin	Both Aboriginal and Torres Strait Islander origin Neither Aboriginal nor Torres Strait Islander origin Not stated / inadequately described

Next of Kin / Emergency Contact details

First name:	Last name:
Phone number:	Relationship:

2.

FUNDING DETAILS (Please select how this program will be funded)

Private Health Fund	Hospital funded
Health Fund Name:	
Membership Number:	
Compensation body/Third party	
Compensation Body Name:	
Claim Number:	
Case Manager Name:	
Case Manager Phone	
Case Manager Email:	

3.

MEDICAL DETAILS

Hospital Admission Date:	Anticipated Discharge date:					
Hospital Name:						
Primary diagnosis and interventions / surgical procedures (if applicable)						
Past medical history						
Any complications during current admission?	Yes	No	Details:			
Any cognitive impairment/delirium?	Yes	No	Details:			
Current functional status (mobility, transfers, ADLs):						
Social History:						
Allergies:						
Infection control alerts	MRSA	Hep B/C	VRE	HIV	Covid-19	Influenza
	Other (specify):					None
Specialist name:						
Specialist phone:		Specialist email:				
Second Specialist name:						
Second Specialist phone:		Second Specialist email:				
GP name + clinic:						
GP phone:		GP email:				

HOME VISIT STAFF SAFETY CHECKLIST

History of aggression or violence?	Yes	No	History of inappropriate behaviour?	Yes	No
History of illicit substance abuse?	Yes	No	Any other risks for home visiting?	Yes	No
Details:					

Patient name:
DOB:
Address:

**or affix bradma here*

4.

HOSPITAL CARE AT HOME SERVICE REQUIREMENTS

Start date	Frequency or specific days	Program length
The patient would otherwise stay admitted in hospital for		day/s without home services
Please select the service/s required:		
IV antibiotics / PICC care		
PICC location:	Insertion date:	
PICC dressing due date:	Length (internal/external):	
PICC location confirmed by x-ray?	Yes	No*
Medication chart attached	Yes	No**
Complex wound care management		
Wound care details:		
Wound care chart attached?	Yes	No**
Patient will be discharged home with 3 days of dressing consumables		
NPWT / VAC therapy		
Device brand	KCI	Smith & Nephew
Disposable (e.g. PICO/SNAP)		
Device serial number (for KCI/Smith & Nephew):		
Canister and foam size and type:	Device pressure setting	Continuous
Intermittent		
Wound care chart attached?	Yes	No**
Patient will be discharged home with 1 complete VAC dressing change		
Drain management		
Type of drain:	Reportable limits?	
Drain management plan:		
Wound care chart attached?	Yes	No**
Patient will be discharged home with all consumables required for drain management		
Stoma care		
Stoma details:		
Stoma chart	Yes	No**
Patient will be discharged home with all consumables required for stoma care		
Other (specify)		
Specific service requirement details:		
* please advise when location confirmed for referral to proceed ** please send when available for referral to proceed		

ADDITIONAL REFERRAL INFORMATION

5.

AUTHORISATION AND REFERRER DETAILS

By signing and sending this referral I declare that:

- The hospital treating specialist declares that the patient is medically stable.
- The patient is suitable to safely engage in home-based care.
- The patient has consented to receiving Ramsay Home Health services at home and has consented to their personal and health information being shared with Ramsay Home Health and the health fund nominated in this form, or the health fund's authorised agent.

- The patient has consented to Ramsay Home Health and the health fund nominated in this form
- The patient has consented to Ramsay Home Health and the health fund nominated in this form contacting the patient, including by electronic means, to ascertain funding eligibility, confirm receipt and facilitate participation of the relevant services.
- The information provided in this form is complete, true and correct to the best of my knowledge.

Referrer Name:	
Referrer Organisation:	
Referrer Role Title:	Referrer Phone:
Referrer Email:	Additional email:
Referrer signature:	Date:

Hospital Care at Home

Clinical and Financial Eligibility Checklist



Ramsay
Home Health

- ☐ [Hospital Care at Home Referral Form](#)
- ☐ Discharge Summary (If available)
- ☐ Any relevant post-discharge orders (If available)

Antibiotics

VAB - 24 hours infusers

- ☐ PICC chart - Date of insertion, location, internal and external length, PICC arm circumference
- ☐ XRAY confirmation of PICC position
- ☐ Medication chart including flush order (signed by Doctor)
- ☐ Connect the first infuser prior to discharge and document connection time
- ☐ Provide first batch of infusers to the patient and advise the patient to store the infusers in the fridge
- ☐ Provide 1 spare PICC line dressing change and 3 days of IV consumables i.e. syringes and flushes

IVAB - Push infuser/short infusions

- ☐ PICC chart - Date of insertion, location, internal and external length, PICC arm circumference
- ☐ XRAY confirmation of PICC position
- ☐ Medication chart including flush order (signed by Doctor)
- ☐ Document time of last dose administered
- ☐ Provide medical vials, IV fluid bags and IV lines from pharmacy
- ☐ Provide 1 spare PICC line dressing change and 3 days of IV consumables i.e. syringes and flushes

IVAB - Vancomycin infusions

- ☐ PICC chart - Date of insertion, location, internal and external length, PICC arm circumference
- ☐ XRAY confirmation of PICC position
- ☐ Medication chart including flush order (signed by Doctor)
- ☐ Document time of last dose administered. For Push Infuser/Short Infusion: Provide medical vials, IV fluid bags and IV lines from pharmacy
- ☐ For 24 hour Infusers: Provide the first batch of infusers and advise the patient to store the infusers in the fridge. Connect the first infuser prior to discharge and document connection time
- ☐ Ensure governing Doctor is aware of Vancomycin levels and dosing
- ☐ Provide 2nd Doctor contact details in case governing Doctor is not available
- ☐ Provide 1 spare PICC line dressing change and 3 days of IV consumables i.e. syringes and flushes.
- ☐ Send latest vancomycin level and renal function tests (Pathology days are Monday to Wednesday only)
- ☐ Please document when the Doctor will review results
- ☐ Referrals for IV Vancomycin require Ramsay Home Health carecoordinator@ramsayhomehealth.com.au to be included on the pathology request form to copied into results

Acute Complex Wound Management

- ☐ Email wound chart including required care regime and product used
- ☐ Send an updated wound care chart if care plan changes prior to discharge home
- ☐ Provide 3 days of dressing consumables

Negative Pressure Wound Therapy (NPWT)

- ☐ Email wound care chart including machine brand (KCI or Smith and Nephew), device pressure setting, dressing type and size, canister size, frequency of dressing changes and date of specialist review
- ☐ Provide 1 complete VAC dressing change, including basic consumables

Drain Tube Care

- ☐ Include Drain Chart (if available)
- ☐ Include type of drain – if it is to be measured only, measured and emptied, or if bag/bottle needs to be changed
- ☐ Reportable limits/communication to specialist (escalation plan if specified by specialist)
- ☐ Provide removal orders for drain tube
- ☐ Provide all consumables required for drain tube care

Stoma Care

- ☐ Provide all necessary information and stoma chart if available
- ☐ Advise if already connected to a Stoma Association
- ☐ Provide all consumables required for Stoma Care