Ramsay Home Health

# Hospital Care at Home Referral

1800 799 732
referral@ramsayhomehealth.com.au

URN:
Surname:
Given name:
DOB: Gender:
*(Affix patient identification label here, if available)*

## 1. PATIENT DETAILS

Mobile number:
Email:
Address for discharge: ( ☐ TICK IF THE ADDRESS FOR DISCHARGE IS ON THE PATIENT ID STICKER)
State: Postcode:

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: Phone number:
Last name: Relationship:

## 2. FUNDING DETAILS (PLEASE SELECT HOW THIS PROGRAM WILL BE FUNDED)

☐ Hospital funded ☐ Private Health Fund name: ☐ Workcover ☐ Other:
Membership Number/Claim Number: If Workcover, 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? ☐ No ☐ Yes Details:
Any cognitive impairment/delirium? ☐ No ☐ Yes Details:
Allergies: ☐ No ☐ Yes Details:
Active infection 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 and clinic:
GP phone: GP email:
Second GP name and clinic:
Second GP phone: Second GP email:

### HOME VISIT STAFF SAFETY CHECKLIST

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

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## 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): Arm circumference: PICC location confirmed by x-ray: ☐ Yes ☐ No

Medication chart attached (Inc. flush order and signed by a Dr): ☐ Yes ☐ No

☐ **Acute Complex Wound Care**

Wound care details:

Wound care chart attached: ☐ Yes ☐ No ☐ Patient will be discharged home with **3 days of dressing consumables**

☐ **Negative Pressure Wound Therapy (NPWT)/ VAC Therapy**

Device brand: ☐ KCI ☐ Smith & Nephew ☐ Disposable (e.g. PICO/SNAP): Date of specialist review:

Device serial number (for KCI/Smith & Nephew): Frequency of dressing changes:

Canister size: Foam size and type:

Device pressure setting: ☐ Continuous ☐ Intermittent

Wound care chart attached: ☐ Yes ☐ No ☐ Patient will be discharged home with **1 complete NPWT dressing change**

☐ **Drain Management**

Type of drain: Reportable limits:

Drain management plan (Inc. removal orders):

Wound care chart attached: ☐ Yes ☐ No ☐ Patient will be discharged home with **all consumables required for drain management**

☐ **Stoma Care**

Stoma details:

Stoma chart attached: ☐ Yes ☐ No ☐ Patient will be discharged home with **all consumables required for stoma care**

Connected to Stoma Association: ☐ Yes ☐ No

☐ **Other (specify)**

Specific service requirement details:

**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 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:

RESET FORM SUBMIT FORM



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