Hospital Care **at Home** Referral

referral@ramsayhomehealth.com.au | 1800 799 732

Ramsay Home Health

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:

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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:

RESET FORM

MR0053234 RHH Hospital Care at Home Referral Form 0425

Version 3 May 2025

Ramsay Home Health — Prescribed Medication Administration Chart

URN:

Family name:

Given names:

Address:

Not a valid prescription unless identifiers present

Date of Birth **Sex:** ☐ M ☐ F

Phone Number

Attach ADR sticker **Diabetic on insulin**

Allergies and adverse drug reactions (ADR)

☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

Medicine (or other)	Reaction / type / date	Initials

Sign ..... Print ..... Date .....

Phone: 1800 799 732 **Email:** referral@ramsayhomehealth.com.au

Hospital Doctor maintaining Clinical Governance post discharge:

Name: .....

Phone: .....

Signature: .....

Authority to remove PICC Line (if known at time of referral):

Insertion date: .....

Name: .....

Signature: .....

Second Doctor for Vancomycin Cases:

Name: .....

Phone: .....

Signature: .....

PICC DETAILS Please provide a copy of the hospital PICC chart and radiology report that includes the following information:

☐ Insertion date ☐ Last dressing date/when next due ☐ Length to skin in cms

☐ PICC location ☐ Xray confirmation of correct PICC location ☐ Upper arm circumference

Date:	Dose	Date Given																				
Medicine: (print generic name)		Time Given																				
	Route	Nurse Signature																				
Start Date: / Cease Date:		Date Given																				
Doctors Name:	Frequency	Time Given																				
Doctors Signature:		Nurse Signature																				
Prescriber number:																						
Date:	Dose	Date Given																				
Medicine: **Normal Saline**	**10-20ml**	Time Given																				
0.9% Sodium Chloride for injection	Route	Nurse Signature																				
Start Date: / Cease Date:	**IV**	Date Given																				
Doctors Name:	Frequency	Time Given																				
Doctors Signature:	**PRN**	Nurse Signature																				
Prescriber number:																						

PRESCRIBED MEDICATION ADMINISTRATION CHART Ramsay Home Health

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