

## PATIENT DETAILS

Title \_\_\_\_\_ Surname \_\_\_\_\_ Ph/Mob. \_\_\_\_\_  
Given Names \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ Medicare No. \_\_\_\_\_  CALD  ATSI  
\_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Next of Kin \_\_\_\_\_  
Relationship \_\_\_\_\_ Ph. \_\_\_\_\_  
Referring Doctor \_\_\_\_\_ Ph. \_\_\_\_\_ GP \_\_\_\_\_ Ph. \_\_\_\_\_  
Specialist \_\_\_\_\_ Ph. \_\_\_\_\_ Specialty \_\_\_\_\_  
Hospital \_\_\_\_\_ Admission Date \_\_\_\_\_ Discharge Date \_\_\_\_\_ UR No. \_\_\_\_\_  
Ward \_\_\_\_\_ Ph. \_\_\_\_\_ Rehab Admission Date \_\_\_\_\_

## FUNDING

Health Fund \_\_\_\_\_ Membership No. \_\_\_\_\_ DRG \_\_\_\_\_ HT \_\_\_\_\_  
 Self Funded \_\_\_\_\_  DVA \_\_\_\_\_  Aged Care (HCP) \_\_\_\_\_  
 Hospital Funded \_\_\_\_\_ Visit No \_\_\_\_\_  Other \_\_\_\_\_  
 Workers Compensation/Third Party: Provider \_\_\_\_\_ Claim No. \_\_\_\_\_  
Case Manager \_\_\_\_\_ Ph. \_\_\_\_\_

## HEALTH DETAILS

Primary Diagnosis \_\_\_\_\_  
Surgical Procedure (if applicable) \_\_\_\_\_ Date \_\_\_\_\_  
Co-morbidities \_\_\_\_\_  
Past History \_\_\_\_\_  
Allergies \_\_\_\_\_  
Hazards (ie. dogs) \_\_\_\_\_ Alerts (clinical/behavioural) \_\_\_\_\_

**SERVICES REQUIRED**  HITH  Rehab  Palliative  Chronic Disease  Aged Care  Other \_\_\_\_\_

## PRESENTING ISSUES

Medication \_\_\_\_\_  
 Wound \_\_\_\_\_  
 Pain \_\_\_\_\_  
 Cardiac \_\_\_\_\_  Gastrointestinal \_\_\_\_\_  
 Respiratory \_\_\_\_\_  Diabetes:  Type I  Type II  
 Continence \_\_\_\_\_  Mental Health \_\_\_\_\_  
 Mobility:  Falls Risk \_\_\_\_\_  ADL Assist \_\_\_\_\_

**ATTACHMENTS**  Medication Authority  Wound Chart  Allied Health Report  Advanced Directive  Microbiology

## ADDITIONAL INFORMATION

Other Services \_\_\_\_\_  
Subsequent Pharmacy \_\_\_\_\_ Commencement Date \_\_\_\_\_

**Referrer Name** \_\_\_\_\_ **Email** \_\_\_\_\_ **Signature** \_\_\_\_\_  
**Position** \_\_\_\_\_ **Ph.** \_\_\_\_\_ **Provider No.** \_\_\_\_\_ **Date** \_\_\_\_\_