Chemotherapy Referral

Ph 1800 854 300 Fax 1800 854 611
Email hss@hss.com.au

home support services

PATIENT DETAILS

Title _____ Surname _____
Given Names _____
Address _____
_____ State _____ Postcode _____
DOB _____
Ph/Mob. _____
Email _____
Medicare No. _____ Ref _____
Concession Card No _____
Pension Card No _____ ☐ CALD ☐ ATSI

Next of Kin _____
Relationship _____ Ph. _____
Referring Doctor _____ Ph. _____
Specialist _____ Ph. _____
Specialty _____
Hospital _____ Admission Date _____
Ward _____ Ph. _____
Discharge Date _____ UR No. _____
GP _____ Ph. _____

FUNDING

☐ Health Fund _____ Membership No. _____ DRG _____ HT _____

HEALTH DETAILS

Primary Diagnosis _____
Surgical Procedure (if applicable) _____ Date _____
Co-morbidities _____

Past History _____
Allergies _____
Hazards (ie. dogs) _____ Alerts (clinical/behavioural) _____

THERAPY REQUIRED

Name of Protocol _____ Commencement Date _____ Frequency _____
Other concurrent treatments _____ Preferred Pathology Provider _____
IV Access ☐ Vein ☐ PICC ☐ CVC ☐ Infusaport ☐ Vascath Date of insertion _____ Next PICC Dressing Date _____

CURRENT COMMUNITY SERVICES

☐ Palliative Care ☐ Domiciliary Care ☐ Other (please specify) _____

PRESENTING ISSUES

☐ Medication _____
☐ Wound _____

☐ Pain _____
☐ Cardiac _____
☐ Respiratory _____
☐ Continence _____
☐ Mobility: ☐ Falls Risk _____
☐ Gastrointestinal _____
☐ Diabetes: ☐ Type I ☐ Type II
☐ Mental Health _____
☐ ADL Assist _____

ATTACHMENTS

☐ Chemo Protocol Medication Authority ☐ Last Pathology Results

ADDITIONAL INFORMATION

_____

Referrer Name _____ **Email** _____ **Signature** _____
Position _____ **Ph.** _____ **Provider No.** _____ **Date** _____