HSS Referral for Services

Ph 08 8372 4999 Fax 08 8372 4900
Email hss@hss.com.au

home support services

Patient Details

Title Surname Given Names

Date of Birth Ph. Mobile

Email Medicare No. ☐ CALD ☐ ATSI

Address State Postcode

Next of Kin Relationship Ph.

Referring Doctor Ph. GP Ph.

Specialist Ph. Specialty

Hospital Admission Date Discharge Date Hospital UR No.

Funding

☐ Health Fund Membership No. Hospital DRG High Trim

☐ Self Funded ☐ DVA

☐ Hospital Funded No. of Visits ☐ Other

☐ Workers Compensation ☐ Third Party Claim No. Case Manager

Health Details

Diagnosis

Surgical Procedure (if applicable) Date

Co-morbidities

Past History

Allergies

Hazards/Infections (dogs, behavioural, MRSA etc)

Services Required

- ☐ Acute/Complex Nursing
- ☐ Medication/IV Therapy
- ☐ General Nursing
- ☐ Wound Management
- ☐ Diabetes
- ☐ Stomal Therapy
- ☐ Continence
- ☐ Palliative Care
- ☐ Chemotherapy
- ☐ Maternity Care Ante/Post Natal
- ☐ Paediatric
- ☐ Mental Health
- ☐ Rehabilitation
- ☐ Occupational Therapy
- ☐ Falls Assessment
- ☐ Physiotherapy
- ☐ Personal Care
- ☐ Domestic
- ☐ Chronic Disease Management
- ☐ Other (please specify)

Specific Treatment Request

Frequency Required Commencement Date

If medication administration is required please complete and attach the medication authority.

Name of Referrer **Referrer's Signature** **Ph.**

Position **Provider No.** **Date**