HSS Referral for Services

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

home support services

PATIENT DETAILS

Title _____ Surname _____ Ph/Mob. _____

Given Names _____ Email _____

Address _____ Medicare No. _____ ☐ CALD ☐ ATSI

_____ State _____ Postcode _____ Next of Kin _____

Date of Birth _____ Relationship _____ Ph. _____

Referring Doctor _____ Ph. _____ GP _____ Ph. _____

Specialist _____ Ph. _____ Specialty _____

Hospital _____ Ph. _____ Admission Date _____ Discharge Date _____

UR No. _____ Program Enrolment 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 ☐ Rehab (Joint) ☐ Rehab (Conditioning) ☐ 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 ☐ Clinical Protocols

ADDITIONAL INFORMATION

_____

_____

_____

Other Services _____

Subsequent Pharmacy _____ Commencement Date _____

Referrer Name _____ **Email** _____ **Signature** _____

Position _____ **Ph.** _____ **Provider No.** _____ **Date** _____

Preferred Physio Provider _____ **Ph.** _____