HSS Referral for Services

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

Submit

HSS 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 _____ Admission Date _____ Discharge Date _____ UR No. _____

Ward _____ Inpatient Rehab Admission ☐ Yes ☐ No

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 _____

Infection control alerts: ☐ Hep B or C ☐ HIV ☐ MRSA ☐ VRE ☐ Other MRO (specify) _____ ☐ Wound Swab pending

SERVICES REQUIRED

☐ HITH ☐ Rehab - Joint ☐ Rehab - Other ☐ Palliative Care ☐ Chronic Disease

☐ Aged Care ☐ Other _____

ISSUES REQUIRING MANAGEMENT

☐ Medication _____

☐ Wound _____

☐ Pain _____

☐ Cognitive _____ ☐ Behavioural _____

☐ Other _____ ☐ Diabetes: ☐ Type I ☐ Type II

☐ Continence _____ ☐ Mental Health _____

☐ Falls Risk _____

ATTACHMENTS (where relevant)

☐ Discharge Summary ☐ Medication Authority ☐ Scripts ☐ Wound Chart ☐ Allied Health Report ☐ Advanced Directive

ADDITIONAL INFORMATION

_____

_____

Preferred Physio Provider _____ Phone _____

Subsequent Pharmacy _____ Commencement Date _____

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

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