Amplar Home Health Referral for Services

Phone: 1800 854 300 Fax: 1800 854 611 Email: home@amplarhealth.com.au

amplar health

Patient details

Title | Surname | Given Names | Date of Birth

Address | State | Postcode

Phone / Mobile | Email | Medicare No.

Referring Doctor | Referring Doctor Phone* | Referring Doctor Email*

Specialist *(if different to Referring Dr)* | Specialist Phone | Specialist Email

GP* | GP Phone* | GP Email*

Hospital | Ward | Admission Date | Discharge Date | ☐ Confirmed ☐ Estimated

Inpatient Rehab Admission ☐ Yes: How many days? ☐ No

Interpretor Required ☐ Yes ☐ No

Are you of Aboriginal and/or Torres Strait Islander origin? ☐ Yes ☐ No

Next of Kin* | Next of Kin Relationship | Next of Kin Phone | Next of Kin Email

Funding

Please select one of the following funding options.

☐ Health Fund ☐ Self Funded ☐ Hospital Funded ☐ Workers Compensation / Third Party

Please provide additional information where applicable.

Health Fund

Fund Name | Membership No.

DRG^ | HT^

Suffix Number^

^BUPA members only.

Hospital Funded

Number of Visits

Service Type

Workers Compensation / Third Party

Provider | Claim No. | RITH *(QLD & SA only)*

Case Manager | Case Manager Phone

Case Manager Email

Relevant Medical Information

Reason for Hospital Admission | Surgical Procedure *(If applicable)* | Date

Relevant Medical History / Co-morbidities

Infection control alerts

☐ Hep B or C ☐ HIV ☐ MRSA ☐ VRE ☐ Other MRO *(Specify)*

Allergies

Services Required

Rehabilitation in the Home

Is the referral in lieu of an inpatient hospital stay?* ☐ Yes ☐ No

☐ The patient would otherwise stay in hospital for ____ days without home services*

☐ Joint ☐ Medibank No Gap Orthopaedics ☐ Other

Please select services required.

☐ Physiotherapy

☐ Occupational Therapy

☐ Nursing *(Including wound review where required)*

☐ Other

Hospital in the Home

Is the referral in lieu of an inpatient hospital stay?* ☐ Yes ☐ No

☐ The patient would otherwise stay in hospital for ____ days without home services*

Please select services required.

☐ IV antibiotics / PICC Care / POC Care

☐ Wound Management

☐ NPWT / VAC

☐ Stoma / IDC / SPC Care

☐ Drain Management

☐ Other

** Fields marked by an asterix are mandatory. Your referral cannot be processed without this information.*

Patient Name	Date of Birth

Current Care Needs

Mobility ☐ Nil Aid ☐ Walking Stick ☐ Crutches ☐ Frame ☐ Wheelchair ☐ Other

Falls Risk ☐ High ☐ Medium ☐ Low

Cognition ☐ Alert / Orientated ☐ Mildly Confused ☐ Very Confused ☐ Other

Living Situation ☐ Lives alone ☐ Lives with partner / others ☐ Has a carer ☐ Cares for others

Community Services Involved ☐ Yes: Specify ☐ No

Wound Management NPWT Type | Device No. | Dressing Type / Size | Frequency

IV Antibiotic Therapy What Type? | PICC / POC Dressing Due | PICC / POC Location

Number of Lumens | Gripper Needle Size (POC)

Please note: *Amplar Home Health cannot process the referral if the relevant Current Care Needs are not clearly documented.*

Attachments

For RITH ☐ Discharge Summary ☐ Allied Health Report

For HITH ☐ Discharge Summary ☐ Medication Chart ☐ Script *(Please select)* ☐ PBS ☐ Non-PBS

☐ Wound Chart *(If applicable)* ☐ Culture & Sensitivities Report *(If applicable)* ☐ PICC / Porta Cath Information *(If applicable)*

Please note: *Amplar Home Health cannot process the referral if the relevant supporting documents are not provided.*

Additional Information

For HITH Subsequent Pharmacy | Commencement Date

Notes

Checklist

For Rehabilitation in the Home Referrals

☐ I have completed and attached an allied health report or discharge summary

☐ I have attached a specialist protocol *(If applicable)*

For Hospital in the Home Referrals

☐ I will send the patient home with 3 days of consumables *(If applicable)*

☐ I have attached an allied health report or discharge summary

☐ I have completed and attached a wound care chart

☐ I have attached the patient's scripts

☐ I have included relevant PICC / PORTA CATH information

☐ I have completed and attached a Medication Chart

☐ I have attached Culture & Sensitivities report

☐ I have referred the patient to a long term care provider

Provider name: Start date:

Referrer Details and Consent

By signing below, I confirm I have informed the patient and obtained their consent that:

A. Their personal information (including health information) will be shared with Amplar Home Health Pty Ltd ("Amplar Health") for the purposes of providing at home services ("Service").

B. Amplar Health will contact the patient about the Services and their nominated Next of Kin if Amplar Health has not been able to contact the patient after three attempts. The Next of Kin will be asked to get the patient to call Amplar Health to discuss next steps.

C. If applicable, Amplar Health may be required to disclose their personal information to their health fund, or their health fund's authorised agency(ies) to ascertain eligibility for the Services, confirm receipt of Services and facilitate their participation in the Services. All parties involved with this program are bound by strict obligations of confidentiality and privacy.

Referrer Name | Title | Phone | Email address to receive communications from Amplar Home Health

Signature | Date