# Hospital Care at Home Referral to Ramsay Connect

Phone 1800 799 732 | Email referral@ramsayconnect.com.au

## 1. REFERRER DETAILS

| | | |
|---|---|---|
| Hospital: | | Phone: |
| Referrer name: | | Email: |
| Referrer role: | | ☐ Preadmission referral ☐ Referral post hospital admission |
| Treating doctor/surgeon: | Phone: | Email / Fax: |

Hospital treating doctor/surgeon declares that the patient is medically stable, has suitable social support to safely engage in home-based care and is not being discharged against medical or allied health advice. The patient has consented to Ramsay Connect disclosing their personal information to the health fund nominated in this form, or its authorised agent (as applicable), to ascertain funding eligibility, confirm receipt of relevant services and facilitate participation. ☐ No ☐ Yes

| | |
|---|---|
| Signature: | Date: |

Please also send through the following documents as relevant;
✓ Surgeon protocol ✓ Discharge summary ✓ Any relevant post-discharge orders
If referral is for Hospital Care at Home IV therapy or NPWT/VAC please also refer to the Hospital Care at Home checklist

## 2. PATIENT DETAILS

| | | | |
|---|---|---|---|
| Name: | | Next of kin: | |
| Address: | | Next of kin phone: | |
| | | Admission date: | Discharge date: |
| D.O.B: | Phone: | Health Fund: | |
| Email: | Mob: | Membership No: | |
| Usual GP: | Phone: | Email / Fax: | |

**Patient Consent**

I declare the Hospital Care at Home program has been explained to me, and wish to participate.

| | |
|---|---|
| Signature of patient/guardian/family member: | Date: |

## 3. PATIENT'S MEDICAL DETAILS (All areas of Patient's Medical Details must be completed)

Primary diagnosis: Interventions / Surgical procedures (if applicable):

Any complications during admission ☐ No ☐ Yes, Details:

PHx:

Infections: ☐ None ☐ MRSA ☐ VRE ☐ CPE ☐ COVID-19 ☐ Other (please specify):

Any known allergies: ☐ No ☐ Yes, Details:

Is the patient receiving any other community care services? ☐ No ☐ Yes, Details:

**Home visit staff safety checklist:** History of aggression or violence? ☐ No ☐ Yes
History of inappropriate behaviour? ☐ No ☐ Yes History of substance abuse? ☐ No ☐ Yes
Are there any other risks for home visiting? (behavioural/social issues, domestic violence, infectious diseases) ☐ No ☐ Yes

Precautions and/or contra-indication have been included in this referral? ☐ No ☐ Yes

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| Patient Name: | D.O.B: |
|---|---|

## 4. PROGRAM REQUEST - HOSPITAL CARE AT HOME PROGRAM (please select program and complete all required areas)

☐ Wound Management ☐ NPWT/VAC ☐ IVAB/PICC CARE ☐ Other (drain tube care/stoma care/IDC):

### ESTIMATE OF REQUIREMENTS (Must be completed for requested program)

| Service Required | Start Date | Frequency | Duration |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

### BED DAY SAVING

Patient would otherwise stay in hospital for ☐ days (best estimate)

| | | | |
|---|---|---|---|
| ☐ Hospital Care at Home checklist completed | ☐ No | ☐ Yes | ☐ N/A |
| ☐ I will send the patient home with 1 day of consumables | ☐ No | ☐ Yes | ☐ N/A |
| ☐ I have included a wound care chart | ☐ No | ☐ Yes | ☐ N/A |
| ☐ I have included a medication and PICC chart | ☐ No | ☐ Yes | ☐ N/A |

## 5. ADDITIONAL INFORMATION

Reset Referral Form

Ramsay Connect

# Prescribed Medication Administration Chart

**URN:**

**Family name:**

**Given names:**

**Address:**

Not a valid prescription unless identifiers present

**Date of Birth** **Sex:** ☐ M ☐ F

**Phone Number**

**Attach ADR sticker** **Diabetic on insulin**

## Allergies and adverse drug reactions (ADR)

☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

| Medicine (or other) | Reaction / type / date | Initials |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Sign ..... Print ..... Date .....

**Phone:** 1800 799 732 **Email:** referral@ramsayconnect.com.au

**Hospital Doctor maintaining Clinical Governance post discharge:**

Name: .....

Phone: ..... Pager: .....

Signature: .....

**Authority to remove PICC Line (if known at time of referral):**

Date of PICC line removal: .....

Name: .....

Signature: .....

**Second Doctor for Vancomycin Cases:**

Name: .....

Phone: .....

Signature: .....

**PICC DETAILS** Please provide a copy of the hospital PICC chart and radiology report that includes the following information:

☐ Insertion date ☐ Last dressing date/when next due ☐ Length to skin in cms

☐ PICC location ☐ Xray confirmation of correct PICC location ☐ Upper arm circumference

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date: | Dose | Date Given | | | | | | | | | | | | | | | | | | | | |
| Medicine: (print generic name) | | Time Given | | | | | | | | | | | | | | | | | | | | |
| | Route | Nurse Signature | | | | | | | | | | | | | | | | | | | | |
| Start Date: / Cease Date: | | Date Given | | | | | | | | | | | | | | | | | | | | |
| Doctors Name: | Frequency | Time Given | | | | | | | | | | | | | | | | | | | | |
| Doctors Signature: | | Nurse Signature | | | | | | | | | | | | | | | | | | | | |
| Date: | Dose | Date Given | | | | | | | | | | | | | | | | | | | | |
| Medicine: **Normal Saline** | **10-20ml** | Time Given | | | | | | | | | | | | | | | | | | | | |
| **0.9% Sodium Chloride for injection** | Route | Nurse Signature | | | | | | | | | | | | | | | | | | | | |
| Start Date: / Cease Date: | **IV** | Date Given | | | | | | | | | | | | | | | | | | | | |
| Doctors Name: | Frequency | Time Given | | | | | | | | | | | | | | | | | | | | |
| Doctors Signature: | **PRN** | Nurse Signature | | | | | | | | | | | | | | | | | | | | |

PRESCRIBED MEDICATION ADMINISTRATION CHART Ramsay Connect