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

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DO NOT WRITE IN THIS BINDING MARGIN

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

Hospital Care at Home
Clinical and Financial Eligibility Checklist

- ☐ Hospital Care at Home Referral Form
- ☐ Discharge Summary (If available)
- ☐ Any relevant post-discharge orders (If available)

Antibiotics

VAB - 24 hours infusers

- ☐ PICC chart - Date of insertion, location, internal & external length, PICC arm circumference
- ☐ XRAY confirmation of PICC position
- ☐ Medication chart including flush order (signed by Doctor)
- ☐ Connect the first infuser prior to discharge and document connection time
- ☐ Provide first batch of infusers to the patient and advise the patient to store the infusers in the fridge
- ☐ Provide 1 spare PICC line dressing change and 3 days of IV consumables i.e. syringes and flushes

IVAB - Push infuser/short infusions

- ☐ PICC chart - Date of insertion, location, internal & external length, PICC arm circumference
- ☐ XRAY confirmation of PICC position
- ☐ Medication chart including flush order (signed by Doctor)
- ☐ Document time of last dose administered
- ☐ Provide medical vials, IV fluid bags and IV lines from pharmacy
- ☐ Provide 1 spare PICC line dressing change and 3 days of IV consumables i.e. syringes and flushes

IVAB - Vancomycin infusions

- ☐ PICC chart - Date of insertion, location, internal & external length, PICC arm circumference
- ☐ XRAY confirmation of PICC position
- ☐ Medication chart including flush order (signed by Doctor)
- ☐ Document time of last dose administered. For Push Infuser/Short Infusion: Provide medical vials, IV fluid bags and IV lines from pharmacy
- ☐ For 24 hour Infusers: Provide the first batch of infusers and advise the patient to store the infusers in the fridge. Connect the first infuser prior to discharge and document connection time
- ☐ Ensure governing Doctor is aware of Vancomycin levels and dosing
- ☐ Provide 2nd Doctor contact details in case governing Doctor is not available
- ☐ Provide 1 spare PICC line dressing change and 3 days of IV consumables i.e. syringes and flushes.
- ☐ Send latest vancomycin level and renal function tests (Pathology days are Monday to Wednesday only)
- ☐ Please document when the Doctor will review results
- ☐ Referrals for IV Vancomycin require Ramsay Connect carecoordinator@ramsayconnect.com.au to be included on the pathology request form to be copied into results

Acute Complex Wound Management

- ☐ Email wound chart including required care regime and product used
- ☐ Send an updated wound care chart if care plan changes prior to discharge home
- ☐ Provide 3 days of dressing consumables

Negative Pressure Wound Therapy (NPWT)

- ☐ Email wound care chart including machine brand (KCI or Smith and Nephew), device pressure setting, dressing type and size, canister size, frequency of dressing changes and date of specialist review
- ☐ **Provide 1 complete VAC dressing change, including basic consumables**

Drain Tube Care

- ☐ Include Drain Chart (if available)
- ☐ Include type of drain – if it is to be measured only, measured and emptied, or if bag/bottle needs to be changed
- ☐ Reportable limits/communication to specialist (escalation plan if specified by specialist)
- ☐ Provide removal orders for drain tube
- ☐ **Provide all consumables required for drain tube care**

Stoma Care

- ☐ Provide all necessary information and stoma chart if available
- ☐ Advise if already connected to a Stoma Association
- ☐ **Provide all consumables required for Stoma Care**

Ramsay Connect

MR0051520 RC Checklist on referral form 0125