BCH
Bass Coast Health

Hospital in the Home - Medical Referral

Surname ..... U.R. No. .....

First Name ..... Gender .....

PATIENT LABEL

Date of Birth ... / ... / ... Age .....

Doctor ..... Ward .....

Address .....

PLACE LABEL HERE

Date of referral: ____ /____ /____ Contact phone number of patient: _____

Sex at birth: _____ Gender: _____

Next of Kin: _____ Contact number: _____

REFERRING DOCTOR TO COMPLETE

Diagnosis / reason for admission:

_____

_____

_____

Relevant past history:

_____

_____

_____

Planned treatment:

_____

_____

_____

_____

_____

* HITH patients requiring medications must have anaphylaxis management completed on medication chart in prn section (0.5mg [0.5ml] of 1:1000 adrenaline IM)

Anticipated discharge date from service: ____ /____ /____

Referring Doctors name: _____ Designation: _____

Signature: _____ Date: ____ /____ /____ Time: _____

Treating GP notified: ☐ Yes ☐ No Name of treating doctor: _____

Review date: ___ /___ /___ Doctor: _____ Phone number: _____

Place of appointment: _____ Time of appointment: _____

Please indicated the following has been attended to:

- ☐ Consent form signed
- ☐ Admission criteria met
- ☐ Pharmacy arranged
- ☐ Pathology orders completed
- ☐ Review appointment booked
- ☐ Medication chart completed

Please tick if there is an advanced care plan ☐

Nurses name: _____ Designation: _____

Signature: _____ Date: ____ /____ /____ Time: _____

HOSPITAL IN THE HOME – MEDICAL REFERRAL

MR/302

BCH3302

BCH Bass Coast Health

Hospital in the Home Iron Infusion Referral

Surname ..... U.R. No. .....

First Name ..... Gender .....

PATIENT LABEL

Date of Birth ... / ... / ... Age .....

Doctor ..... Ward .....

Address .....

PLACE LABEL HERE

Phone 5671 3439/Email hith@basscoasthealth.org.au

URGENT Iron Infusions need to be discussed with Hospital In The Home. Limited capacity will affect urgent iron infusions.

Please Note:

- Patient is required to be self-caring and mobile, not confused or agitated
- Referrals will be triaged in collaboration with the HITH consultant and HITH nursing staff
- HITH Iron Infusion will operate during business hours Monday – Friday 0900am-1500pm
- All patients will be contacted via phone for an appointment date and time
- Medical follow up post infusion/transfusion will be by the patient's GP or medical specialist

Patient Phone no: _____

Allergies: _____

Relevant PHx: _____

_____

☐ Iron Infusion, not an emergency
Verbal consent obtained: ☐ Yes
Risks and benefits discussed: ☐ Yes
☐ Confirmation: Patient is self-caring, mobile not confused / agitated

Clinical Reason

☐ Iron Deficiency Anaemia
☐ Other (please specify) _____

All documentation to be emailed to hith@basscoasthealth.org.au
Infusion will NOT be confirmed until all documents received.

NOTE: blood test results should be no older than 4 weeks old at time of referral.

Documentation required:

☐ FBE
☐ Iron studies
☐ Medical Summary
☐ Other i.e. Medical Specialist documentation

Referring Doctor:

Name: _____

Clinic: _____

Contact details: _____

Thank you for your inquiry regarding referrals to HITH. If you have any further questions please do not hesitate to contact us by email at hith@basscoasthealth.org.au or by telephone 03 5671 3439.

HOSPITAL IN THE HOME
IRON INFUSION REFERRAL

MR/302