NSW GOVERNMENT Health
South Eastern Sydney
Local Health District

Facility:

REFERRAL - AMBULATORY CARE UNIT

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

SES010413

❑ Prof Peter Smerdely ❑ Dr Louise Baird ❑ Dr Sarah Baldwin ❑ Dr Kannie Chuang ❑ Dr Chris Dedousis
❑ Dr Litsa Morfis ❑ Dr Grant Pickard ❑ Dr Tony Youssef ❑ Dr Yun Xu

Patient Family Name: _____ **Given Name:** _____

DOB: _____ **MALE / FEMALE:** (please circle)

Address: _____

_____

Phone Number: _____ **Mobile No:** _____

Medicare No: ☐☐☐☐☐☐☐☐☐☐ **Medicare Expiry Date:** ____/____

Note: – include patient's reference number as the eleventh number of the Medicare card.

Interpreter Required: Yes / No Dialect: _____

Reason for referral:

Diagnosis/Medical History:

If medication required please complete the Community Medication and Authorisation Record

❑ **Please tick if patient arriving by ambulance.**

Referral Dr: _____ Contact No / Page No: _____

SIGNATURE: _____ **DATE:** _____

Referring Dr	
Provider No.	
Telephone	
Address	

Please complete this section in full or with practice stamp

Practice Stamp

Fax completed form: 9113 1923

Holes punched as per AS2828.1:2012
BINDING MARGIN - NO WRITING

S0638 280313

REFERRAL - AMBULATORY CARE UNIT SES010.413

SURNAME
OTHER NAMES
DOB SEX AMO

FOR MEDICAL RECORD USE ONLY

• MEDICAL RECORD COPY •

South Eastern Sydney Illawarra Area Health Service

COMMUNITY MEDICATION AUTHORISATION & RECORD

MRN BAR CODE

AFFIX PATIENT IDENTIFICATION LABEL HERE

1st Prescriber to Print Patient Name & Check Label Correct:

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***Original MUST be sent home with patient**

ALLERGIES & ADVERSE DRUG REACTIONS (ADR) ☐ Nil Known ☐ Unknown

Drug (or other)	Reaction / Type / Date	Initials	Drug (or other)	Reaction / Type / Date	Initials

In the event of an anaphylactic reaction administer adrenaline 1:1000 0.3 mg – 0.5mg (0.3mL – 0.5mL) by intramuscular injection as per local hospital policy

Medication (Print Generic Name)		Medication (Print Generic Name)	
Dose	Fluid (IV Only)	Dose	Fluid (IV Only)
Route	Volume (IV Only)	Route	Volume (IV Only)
Frequency	Rate (IV Only)	Frequency	Rate (IV Only)
Indication	Start Date	Indication	Start Date
Special Instructions	Completion Date	Special Instructions	Completion Date
MO Signature	Date Ordered	MO Signature	Date Ordered
MO Name (Print	MO Contact No.	MO Name (Print	MO Contact No.

Date	Time	RN Signature	Date	Time	RN Signature

BINDING MARGIN – DO NOT WRITE