South Eastern Sydney Local Health District

NSW GOVERNMENT

Facility: St George Hospital

REFERRAL – DAY MEDICAL AND INFUSION CENTRE

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

Referral to: Dr Madeleine Wilkinson (GMU Consultant)

Patient's Phone: _____ Mobile: _____

Patient's email address: _____

Patient's preferred contact: ☐ Mobile ☐ Phone ☐ Email Interpreter Required ☐ Yes ☐ No Language/dialect: _____

Is the patient Aboriginal and/or Torres Strait Islander?

☐ Yes, Aboriginal only ☐ Yes, Torres Strait Islander only ☐ Yes Aboriginal and Torres Strait Islander ☐ No

Medicare Number: | | | | | | | | | | | | **Expiry Date:** ____/____/____

Special needs/reasonable adjustments required for disability: ☐ No ☐ Yes description: _____

To be completed if the patient has a carer.

Name of carer: _____ Phone: _____

Email address: _____

Compensable status: ☐ DVA ☐ WorkCover ☐ Motor vehicle third party insurance ☐ Other _____

Reason for referral: *(e.g. investigation of, type of treatment requesting - dressing, infusion, biopsy, transfusion)*

Treatment required:

If this referral is for medication administration, specify following.

Medication name: _____ **Dose:** _____ **Route:** _____ **Frequency:** _____

If this referral is for venesection, specify volume _____ **mL and frequency:** _____

Diagnosis / Medical History:

HEALTHCARE PRACTITIONER DETAILS			
GP Name		**GP Phone Number**	
GP Address		**GP Fax Number**	
Referring Doctor:		**Provider Number:**	
Contact/Pager Number:	**Referring Doctors Signature:**		**Date of Referral:**

ONCE REFERRAL FORM IS COMPLETE PLEASE FAX TO 9113 1923

OFFICE USE ONLY

Date referral received:		**Treatment Required in:** ☐ Bed ☐ Chair	
Accepting Doctor:		**To be seen within:**	
Date Accepted:		**Interpreter Booked:** ☐ Yes ☐ No ☐ Not Available	
Date of Appointment:			

SES010413

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

REFERRAL – DAY MEDICAL AND INFUSION CENTRE SES010.413

NHSIS0638 060325

NO WRITING

UTHER 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:

*Original MUST be sent home with patient

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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