TORRENS HEALTH

Referral Form (Allianz Care Australia)

Please indicate if you would like to recieve a referral receipt via ☐ Fax ☐ Email ☐ Phone ☐ Not required

1. REFERRER DETAILS

Hospital:	Phone:	Fax:
Referrer name:	Email:	
☐ Preadmission referral ☐ Referral post hospital admission		

2. PATIENT DETAILS

Name:		Next of kin:	
Address:		Next of kin phone:	
State:			
DOB:	Phone:	Admission date:	Discharge date:
Email:	Mob:		

FUNDING

☐ Allianz Care Australia ☐ Policy number (if available):

3. PROGRAM OR SERVICES REQUIRED

☐ Hospital care at home ☐ Rehabilitation at home ☐ Allied health ☐ GP Telehealth

4. PATIENT'S MEDICAL DETAILS (THIS SECTION MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED)

Condition/Diagnosis/PHX:	ADL/Safety alerts:	
☐ Hospital treating doctor/surgeon declares medically stable	Allergies:	RAPT score:
☐ Special surgeon protocols (please attach to referral)	☐ Sufficient family/social support available to client at home	
Treating doctor/surgeon:	Phone:	Fax:
Usual GP:	Phone:	Fax:

5. SERVICE REQUIREMENTS (PLEASE COMPLETE ALL APPLICABLE FIELDS)

NURSING SERVICES		ALLIED HEALTH SERVICES		
☐ Wound Management	☐ Medication Management	☐ Physiotherapy	☐ Psychology	
☐ IV Therapy/PICC Care	☐ Pain Management	☐ Podiatry	☐ Exercise Physiology	
☐ NPWT/VAC	☐ Drain Management	☐ Dietitian	☐ Occupational Therapy	
		☐ Personal Care	☐ Meals	☐ Home Help

☐ Wound care chart to be provided & minimum 3 day's supply of products/dressings sent with patient

DESCRIBE CARE REQUIREMENTS

Start date: Frequency: Duration:

6. AUTHORISATION (THIS SECTION MUST BE COMPLETED FOR REFERRAL TO BE PROCESSED)

Name: Signature: Date:

Role title:

Please email form to hith@torrenshealth.com.au OR call 1300 729 122

torrenshealth.com.au/hospital-in-home