PROGRAMMED Care

Referral for Services

F 1300 435 488

T 1300 364 724

Level 1, 333 Collins Street, Melbourne VIC 3000

PATIENT DETAILS

Surname: _____

First name: _____

Address: _____

_____

Phone: _____ DOB: ___ / ___ / _____

Health fund: _____ MBR No: _____

DVA / Workcover / Compensable *(please circle)*

Entitlement number: _____

NOK: _____ Phone: _____

FUND CHECK *(Programmed Care use only)*

Name: _____ Date: ___ / ___ / _____

Home nursing / OT / Physiotherapy *(please circle)*

Rebate eligible: Y / N Cover used: Nil / _____

Other health provider check: _____

REFERRAL DETAILS

Date of referral: ___ / ___ / _____

Referral source: _____

Ward: _____

Date of hospital admission: ___ / ___ / _____

Diagnosis: _____

_____

Referral contact name: _____

Contact phone: _____

Date of first visit: ___ / ___ / _____

Time guideline: _____

Instructions for access: _____

_____

Consultant provider number: _____

Hospital provider number: _____

Next OPD date: ___ / ___ / _____

GENERAL PRACTITIONER DETAILS

Name: _____

Phone: _____

Provider number: _____

TREATMENT REQUEST

☐ WOUND MANAGEMENT

☐ Post-surgical ☐ Ulcer

☐ Traumatic ☐ Other

Details: _____

_____

_____

_____

☐ MEDICATION MANAGEMENT

Details: _____

Medication authorisation organised: Yes / No

☐ CONTINENCE ASSESSMENT / MANAGEMENT

Details: _____

☐ STOMAL THERAPY

Details: _____

☐ PALLIATIVE CARE

Details: _____

☐ PERSONAL CARE ASSISTANCE

Details: _____

☐ DOMESTIC ASSISTANCE

Details: _____

☐ OCCUPATIONAL THERAPY ASSESSMENT

Details: _____

☐ EQUIPMENT PROVISION

Details: _____

☐ SPEECH THERAPY

Details: _____

☐ PHYSIOTHERAPY

Details: _____

☐ PODIATRY

Details: _____

☐ OTHER: _____

_____

_____

_____

_____

Notes: _____

_____

_____

I _____, the treating Medical Practitioner, believe that treatment provided by Programmed Care will support either early discharge from hospital, prevent hospitalization or readmission. For DVA clients, the above treatment is appropriate and I authorize Programmed Care is to provide this care.

_____ _____

Signature *Date*