

Unit Record No. _____
Surname _____
Given Names _____
DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

EMAIL COMPLETED REFERRAL FORM TO: adult.HITH@mater.org.au

Referral date: ____ / ____ / ____ Inpatient hospital clinical area: _____
Hospital admission date: ____ / ____ / ____ Planned transfer to HITH date: ____ / ____ / ____ Estimated discharge date from HITH: ____ / ____ / ____
Interpreter required: Yes No If Yes, language spoken: _____

Relevant Clinical Presentation

Consultant name: _____ Specialty/Team: _____ Preferred contact number: _____

Disciplines Required

Nursing Physiotherapy Occupational Therapy Speech Pathology Other (*specify*): _____

Primary Diagnosis and Reason for Referral

Comorbidities/Complications (including recent medical history)

Treatment Required

Wound care +/- drain – Duration of therapy: _____ Drain type: _____
 Wound Management and Assessment form attached
 Medication – Medication name: _____ Duration of therapy: _____
 For IVABs – organism (if known): _____
 New medication chart for HITH completed and copy of *Stat Sheet* attached to referral
 Other treatment: _____
Duration of therapy: _____

Intravenous Access Device

Peripheral cannula PICC Portacath Other (*specify*): _____
Date of insertion: ____ / ____ / ____ Date last accessed: ____ / ____ / ____
PICC can be removed at the end of treatment: YES NO
Authorising doctor's name: _____ Signature: _____ Date: ____ / ____ / ____

Safety Alert

Known allergies: _____ Reaction type: _____
Infection control/cytotoxic issues: _____ Precaution type: _____
Potential staff risks:
 Behavioural/social issues: _____
 Animals on property: _____

PATIENT INFORMED OF TRANSFER TO HITH: YES NO

Referrer Details

Referrer's name: _____ Designation: _____ Contact number: _____



Binding margin - do not write. Do not reproduce by photocopying. All clinical form creation and amendments must be conducted through Health Records.

MATER AT HOME HOSPITAL IN THE HOME (HITH) REFERRAL