mater health

HOSPITAL IN THE HOME (HITH) REFERRAL

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

F4181

EMAIL COMPLETED REFERRAL FORM TO: materathome@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: .....

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 ***(F2795)*** 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: .....

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.

HOSPITAL IN THE HOME (HITH) REFERRAL 100

10/19
Ver. 3.00
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