Metropolitan Referral Unit - Paediatric referral form

Government of South Australia
SA Health

Referral Fax 1300 546 104

PATIENT INFO Sticker/MR10/UR No:

Surname: First name:

Address:

Suburb: P/Code:

☐ Male ☐ Female ☐ DOB: / /

Tel: Mob:

Address where care to be provided (if not usual address)

Address:

Suburb:

Referral source ☐ NALHN ☐ SALHN ☐ WCHN

Date of referral: / / **Time:** / /

Requested service commencement date: / /

Referring hospital/agency:

Ward/unit: Ext number:

Admission date: / / Discharge date: / /

USUAL LIVING:

☐ With parents ☐ With family/friends

☐ With Carer/Legal Guardian ☐ Other:

NOK: **(Relationship):** **NOK:** **(Relationship):**

NOK Phone(s): **NOK** Phone(s):

INDIGENOUS STATUS: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown

COUNTRY OF BIRTH: ☐ Australia ☐ Other *(specify)*: **GP/Practice**:

Interpreter required? *specify* **GP** Phone:

KNOWN RISKS TO COMMUNITY STAFF VISITING HOME: (Environment/Animals /Aggression/vulnerable child/DCP/CARL involvement)

PRIMARY DIAGNOSIS: (including duration of symptoms):

PMH and secondary conditions:

Gestation at birth: /40

ALLERGIES: **MRO:** ☐ MRSA ☐ VRE ☐ Other MRO *(specify)*:

Respiratory rate: Respiratory distress: SpO_2: Pulse Rate:

Cap. Refill: BP: Temperature: Weight:

MANAGEMENT PLAN / CARE REQUESTED: (please attach with this form any additional information to assist community care delivery)

RESPIRATORY ASSESSMENT ☐ (please complete the following)

Respiratory distress/WOB details:

Oxygen requirements:

(AND/OR) HYDRATION ASSESSMENT ☐ (please complete the following)

Usual feeds:

Feeding in hospital:

Additional information/Other Care Requested: (eg wound care, asthma education, midwife visit, medication management)

Date and location of next Outpatient Appt: (if known) or GP follow-up plan:

Attached: ☐ Medication Authority ☐ Asthma Discharge/Action/Recovery Plan(s) ☐ Discharge Summary ☐ Fluid balance

☐ RDR Chart ☐ PICC/Other Vascular line details ☐ Wound Chart ☐ Other information attached:

Community Services and New referrals	**Current/New**	Details - contact name and phone number	Referred Date

Equipment in place (describe):

Equipment requested:

Referrer's signature:	Print Name:
	Role/designation: Contact number:

Please complete form and Fax to 1300 546 104. Access and download forms and resources: **www.sahealth.sa.gov.au/MRU** or **Phone 1300 110 600**.