Metropolitan Referral Unit

Referral Fax 1300 546 104

COVID-19 Remote Surveillance Referral

Government of South Australia
SA Health

Referral source ☐ COVID-19 clinic ☐ Public Hospital ☐ GP ☐ Other

PATIENT INFO Sticker/MR10/UR No: ____________________
Surname: ____________________ First name: ____________
Address: ____
Suburb: ____
____________________ P/Code: ____________
☐ Male ☐ Female DOB: ____/____/____
Telephone: ____
Mobile: ____
Email: ____

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

Date of referral: ____/____/____ Time: ____/____/____

Requested Service Commencement date: ____/____/____

Referring Hospital/ Agency: ____________________

Ward/Unit: ____________________ Ext No: ____________

Admission date: ____/____/____ Discharge date: ____/____/____

USUAL LIVING:
☐ Alone ☐ With Family/Spouse
☐ Homeless ☐ Friend/s ☐ Other: ____________________

NOK: ____________________ (Relationship): ____________________ GP/Practice: ____________________

NOK Phone (s): ____________________ GP Phone: ____________________

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

COUNTRY OF BIRTH: ☐ Australia ☐ Other *(specify)*: ____________________

Interpreter required? *specify* ____________________

PRIMARY DIAGNOSIS: ____
____

PMH & Secondary Conditions: ____
____

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

MANAGEMENT PLAN COVID-19 REMOTE SURVEILLANCE

Has GP been notified ☐ Yes ☐ No

Suitable for home isolation ☐ Yes ☐ No

Isolation Order implemented ☐ Yes ☐ No

Self-isolation instructions provided: ☐ Yes ☐ No

Date self-isolation commenced: ____/____/____

Swabbed: ☐ No ☐ Yes, date: ____/____/____

Consent to contact: ☐ Yes ☐ No

Suggested call frequency (daily/BD/other): ____________________

Any other health professional contacting patient on a regular basis? No ☐ Yes ☐ Specify: ____________________

Others in Home: No ☐ Yes ☐ Specify: ____________________

Current Symptoms please describe: ____
____
____
____
____

Referrer's signature: ____________________	Print Name: ____________________ Role/Designation: ____________________ Contact number: ____________________

Please complete form and FAX to 1300 546 104 or Phone 1300 110 600