Government of South Australia
SA Health

VIRTUAL CLINICAL CARE SERVICE REQUEST

(MR-VCC)

Hospital/Site: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex/Gender: .....

PART A:	**To be completed by the Referrer**		
Date of Referral:		**Site:**	
Name of Referrer:			
Phone:		**Mobile:**	
Fax:		**Email:**	
Client Address and Phone Contacts			
Address:		**Postcode:**	
Mobile:		**Phone:**	
Indigenous Australian	Yes ☐ No ☐	**CALD:**	Yes ☐ No ☐
Ethnicity – other:			
Clinical Information *(if medical summary not attached)*			
Key reason(s) for referral:			
Relevant Medical History: Eg COPD HFrEF HFpEF T2DM			
Action Plan: *(Please attach with the referral)*	☐ Chest Pain ☐ Heart Failure ☐ Asthma ☐ Blood Pressure ☐ COPD ☐ Other:		
Visual Impairment:	Yes ☐ No ☐	*Details:*	
Lives alone:	Yes ☐ No ☐	*Details:*	
Carer:	Yes ☐ No ☐	*Details:*	
Hearing Impairment:	Yes ☐ No ☐	*Details:*	
Fluid Restriction:	Yes ☐ No ☐	*Details:*	
Current Weight:	(kg)	**Dry Weight:**	(kg)
Allergy Details *(if known)*			
Allery to:			
Reaction Details:			
Rescue Medication:			
Next of Kin Details			
Name:		Relationship:	
Address:			
Mobile:		Phone:	
GP Details			
GP Name:			
Practice Name:			
Address:			
Phone:		**Fax:**	
Email:			

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Medication Details			
Medication Name	**Dose**	**Route**	**Frequency**

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Monitoring Parameters

Limits set by GP: ☐ **Limits set by Nurse:** ☐

Note: Please set the vital signs limits
(if they are not set the generic limits below will be used until completed parameters are received)

Vital	Lower Limit	Target	Upper Limit
Pulse			
SBP			
DBP			
Sp02			
Glucose			
Weight			
Temperature			

Use Generic Limits Below: ☐

Vital	Lower Limit	Upper Limit
Pulse	60	100
SBP	100	150
DBP	60	90
Sp02	95	
Glucose	4.0	8.0
Weight	Weight will be set using the first weight recorded whilst on VCC	Change 2 kg over 2 days
Temperature		38°C

Additional Notes or Special Requirements

Form Completed By:		Date:	

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Part A: VCC Client Consent Form

To be completed by the Referrer

I, (insert client name)_____

agree to participate in this home monitoring program and I understand that I am free to withdraw at any time.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I understand that the monitoring equipment is the property of the Rural Support Service and I agree to return it upon finishing the program.

I agree to complete a feedback questionnaire upon finishing the program.

I give permission for the Virtual Clinical Care Home Tele-Monitoring Service to contact my nominated medical clinic and have access to my current Health Summary and Medication List.

My nominated medical clinic is _____

Signature: _____ Date: _____

Name of Referrer
(*please print):*

_____

Signature: _____ Date: _____

Please email or fax completed VCC Service Request and Consent Forms to VCCHUB@sa.gov.au

Submit

Email: VCCHUB@sa.gov.au
Fax: (08) 8553 4298
Telephone: 1300 678 182

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PART B:	**To be completed by the Virtual Clinical Care Nurse**

Access to Results – GP

☐ Yes – Monthly Report Required ☐ Yes - Database Access Required

Access to Results - Nurse or Allied Health Permission

Surname:		Given Name:	
Workplace Name:			
Address:		Postcode:	
Phone:		Fax:	
Email:			

☐ Yes – Database Access Required ☐ Yes - Monthly Report Required

Personal Escalation Contact Points

First Personal Contact

Name:		Relationship:	
Mobile:		Phone:	
Availability:			

Second Personal Contact ☐ **N/A**

Name:		Relationship:	
Mobile:		Phone:	
Availability:			

Clinical Escalation Contact Points

First Escalation Point

Name:		Role:	
Location:			
Mobile:		Phone:	
Email:		Fax:	
Availability:			

Second Escalation Point ☐ **N/A**

Name:		Role:	
Location:			
Mobile:		Phone:	
Email:		Fax:	
Availability:			

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Kit Delivery

New Kit Required: ☐ Yes ☐ No

Use kit already at site *(re-assignment)*: ☐ Yes
Kit Number:

Kit Delivery Address:

Name:
(staff member expecting kit delivery)

Does the client use a mobile phone in their home? ☐ Yes ☐ No

Kit Installation

Monitoring Commencement Date:

Schedule Time: ☐ 0600 ☐ 0630 ☐ 0700 ☐ 0730 ☐ 0800 ☐ 0830 ☐ 0900 ☐ 0930 ☐ 1000

**Please advise the client that the tablet will start prompts 30 minutes prior to the scheduled interview time*

Number of days per week to be monitored: ☐ 3(M,W,F) ☐ 5(M-F) ☐ 7 days

Days to be monitored: ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

Interview Type:
(tick all that apply) ☐ Heart Failure ☐ COPD ☐ T1DM ☐ T2DM ☐ HTN

Peripherals:
(tick all that apply) ☐ Oximeter ☐ BP ☐ Scales ☐ Glucometer ☐ Thermometer

Special Request: ☐ Bariatric Scales *(if weight > 120kg or unsteady and requires a larger platform)*

BP Cuff Size: *(tick one)* ☐ Small Cuff = 18-21cm ☐ Medium Cuff = 22-31cm ☐ Large Cuff = 32-45cm

Form Finalised by VCC Nurse:		**Date:**	