My Home Hospital
Delivered by Amplar Health Home Hospital

Patient Referral Form

Government of South Australia
SA Health

Referrals can be made 24/7
Phone **1800 111 644** | Fax **1800 333 644** | Email **referrals@myhomehospital.com.au**

PATIENT INFO

Sticker/UR No
Family Name
Given Name
Address
Suburb P/Code
Sex ☐ Male ☐ Female ☐ Other
*gender is captured during admission process
DOB / / ☐ Patient is 13 years or older
Telephone Mobile
Is the patient of Aboriginal or Torres Strait Islander origin?
☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Neither
Address where care to be provided, if not usual address
Please note eligibility is based on location of service delivery
Address
Suburb P/Code

Alternative contact
Name
Phone

Please indicate if the patient has a third party decision maker* (should this be required)
☐ Parent or guardian (for patient under 16 years of age) **OR**
☐ Substitute decision-maker appointed under an Advance Care Directive **OR**
☐ Person responsible
Name
Relationship Phone

*For more information on who can consent please visit: sahealth.sa.gov.au/consenttomedicaltreatment

REFERRAL FROM (LOCATION)

☐ Emergency Department ☐ Home ☐ GP clinic
☐ Inpatient ☐ RACF ☐ Specialist clinic
☐ Outpatient ☐ Other
Hospital name (please specify)

REFERRAL DETAILS

Referrer name
Home team / unit
Role
Email
Phone (mobile preferred)
Preferred method of contact ☐ Phone ☐ Email
Responsible Consultant
☐ If My Home Hospital was not available it is expected this patient would require admission to a public hospital bed.
Date of referral / / Time am/pm

Requested service commencement
Date / / Time am/pm

PRIMARY CONDITION

Reason for admission
Does the patient require an interpreter? ☐ Yes ☐ No
(if yes, please specify language)
Patient currently holds a Medicare Card ☐ Yes ☐ No
Where possible, provide card number

Individual reference number Expiry date /

If patient holds private health insurance or is a DVA card holder, patient has elected not to use that funding and agrees to be admitted to My Home Hospital as a public patient.
☐ Yes ☐ No ☐ N/A

Confirm patient is not a compensable patient (ie. WorkCover, MVA insurance). Compensable patients cannot be accepted by My Home Hospital. ☐ Confirmed

Does the patient have an Advance Care Directive or 7 Step Pathway? ☐ Yes ☐ No

Please continue to next page and ensure document is signed before submitting.

USUAL GP DETAILS (If available and if not referred by GP)

Name | Practice name

Phone

CLINICAL INFORMATION (information can also be supplied by attaching documentation)

Presenting clinical issue, including relevant observations

Relevant past medical history

Allergies / adverse reactions

Current medications (can be attached separately)

Treatment already provided and/or commenced

INFECTION CONTROL ALERTS

☐ Hep B or C ☐ HIV ☐ MRSA ☐ VRE ☐ Other MRO (specify)

Respiratory precautions required? ☐ Yes ☐ No

If your patient has recently been in hospital, are any of the existing hospital-acquired complications present currently

☐ Pressure injury ☐ Falls resulting in fracture or intracranial injury ☐ Healthcare associated infection ☐ Renal failure

☐ Venous thrombosis ☐ Medication complications ☐ Delirium ☐ Incontinence

PLEASE ATTACH WHERE AVAILABLE

☐ Health Summary ☐ Mental Health Assessment ☐ Discharge Summary ☐ Medication Summary

☐ Wound Chart ☐ PICC/Other Vascular line details ☐ Advance Care Directive

☐ Investigations (pathology/imaging) ☐ IDC/SPC Management

☐ Other information attached (specify)

REFERRER SIGNATURE

☐ I confirm I have discussed the My Home Hospital service with the patient or third party decision maker (as identified above) and they have consented to a referral to My Home Hospital.

Signature | Print name | Date / /

For additional information, visit myhomehospital.sa.gov.au or phone 1800 111 644.
Without a complete referral form eligibility assessment may not be possible which can delay My Home Hospital admission.

My Home Hospital is delivered by Amplar Health Home Hospital Pty Ltd.

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