Ramsay Health Care

ADMISSION REFERRAL FORM

TO BE COMPLETED BY DOCTOR
Please PRINT clearly in block letters.

URN: _____

Last Name: _____

Given Names: _____

D.O.B: _____ Sex: _____

(Affix Patient Identification label here)

RHC100190

Please Admit

☐ Mr, ☐ Ms, ☐ Mrs, ☐ Dr, ☐ Miss, ☐ Master: ..... (Surname) ..... (Given Names)

Address: .....

Telephone: ..... (Home) ..... (Business) ..... (Mobile)

Date of Birth: ..... Sex: .....

Admission Details **Facility to be admitted to:**

Proposed operation/treatment: .....

.....

Date of Admission: ...../...../..... **Expected length of stay:** ☐ Day Only ☐ Overnight or ☐ Longer..... nights

Date of Operation: ...../...../..... ICU request: ☐ Yes ☐ No Intubated: ☐ Yes ☐ No Image intensifier: ☐ Yes ☐ No

Indication for ICU: .....

.....

Estimated duration of operation: ..... **mins** **Type of Anaesthetic:** ☐ General ☐ Local

Clinical Details

Presenting Symptoms: .....

.....

Provisional Diagnosis: .....

.....

Other conditions present: .....

.....

Infection Risk: ☐ Yes ☐ No History of ☐ MRSA ☐ VRE Other: ..... VTE Risk: ☐ High ☐ Low

CURRENT MEDICATIONS: .....

.....

.....

Is the patient taking any oral anticoagulants or antiplatelet medications? ☐ Yes ☐ No **If Yes, date when ceasing:** ...../...../.....

History of Diabetes: ☐ Yes ☐ No If yes, what type? ☐ Type 1 ☐ Type 2 Treated by: ☐ Insulin injection ☐ Tablet ☐ Diet

ALLERGIES: .....

Expected Item Number(s):

Equipment Details:

Implantable device: ☐ Implanting Device ☐ Removing Device

Type:	Type:
Company: ☐ Contacted	Company: ☐ Contacted

Will the prosthesis used attract a gap payment? ☐ No ☐ Yes if so, gap estimate $ .....

Has informed financial consent been provided? ☐ Yes ☐ No Patient Signature: .....

Pre-operative instructions (including tests required):

☐ Pre-admission clinic attendance required

☐ Pathology tests: .....

☐ Investigations: ☐ X-ray/ultrasound ☐ ECG ☐ Other .....

☐ Anaesthetic Consult

☐ Drug Orders on Admission (drug order valid 24 hours only) .....

.....

☐ Special Instructions: .....

.....

Obstetric Details:

Parity: ..... EDC: ..... Blood Group: ..... Rh: ..... Hb: .....

Anti-D & agglut screen: ..... Rubella HIA titre: ..... HBs Ag: .....

*Consent (over page) to be completed and signed

Admitting Doctor

Name: ..... Signature: ..... Date: ...../...../.....

ADMISSION REFERRAL FORM

RHC35

Version 1.5 – January 2019