



Delivered by a joint venture between Calvary Ampliar Health

Patient Referral Form



Government of South Australia
SA Health

Phone 1800 111 644 | Referral Fax 1800 333 644

Between 0800 – 2000, referrals can be by phone (1800 111 644), email (referrals@myhomehospital.com.au) or fax (1800 333 644)
Between 2000 – 0800, please phone 1800 111 644 and a Care Coordinator will advise next steps.

PATIENT INFO

Sticker/UR No

Family Name

Given Name

Address

Suburb P/Code

Male Female Other

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 SOURCE

Emergency Department GP SAAS

Outpatient Inpatient

Other

Hospital name (please specify)

REFERRAL DETAILS

Referrer name

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 Calvary Amplar Health JV Pty Ltd, a joint venture between Calvary Health Care and Amplar Health.

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