CALVARY HEALTH CARE BETHLEHEM

REFERRAL FOR ADMISSION

Phone: 9834 9423 **Fax: 9834 9494**

Email to:

BET-Access&Intake@calvarycare.org.au

Referral To - (please choose one)	Referral Reason
☐ Inpatient	☐ Terminal Care
☐ Community Palliative Care Services	☐ Assessment
☐ State-wide Progressive Neurological Diseases Services (SPNDS)	☐ Symptom Management
Do not use this form for NDIS....for an **NDIS Service Request Form** click > **here**	☐ Maintenance

Date of Referral:

* Fields are **mandatory** and the referral ***cannot be processed*** unless completed. Thank you

* Referrer Details	Patient Details
Organisation:	* **CONSENT** ☐
Name:	* **Title** &/or **Preferred Pronouns:**
Designation:	* **Surname**
Phone:	***Given Names(s):**
Mobile:	***Address:**
Fax:	***Home Phone:**
Email:	***Mobile:**
Address:	***Email:**
* **Name of Referring Doctor as per AHPRA registration if different from Above:**	Preferred mode of Contact: ☐ home phone ☐ mobile ☐ email
	* **Date of Birth:**
* **Referring Doctor Provider Number:**	Biological birth: ☐ Male ☐ Female ☐ Other
	Gender: ☐ As above ☐ Prefer not to answer ☐ Non-Binary ☐ Different term: ....
	* **Country of Birth:**
* Primary Support Person / Carer (ie., NOK / MTDM)	Preferred Language:
Surname:	Interpreter Needed: ☐ Yes ☐ No
First Name:	☐ Aboriginal ☐ Torres Strait Islander ☐ Neither
	Religion:
Phone/ Mobile	Medicare | Insurance
Email	***Medicare No:**
Relationship to Patient	Medicare Reference No:
Lives with Patient ☐ Yes ☐ No	Private Health Fund:
Preferred Contact Person: (incl. name and contact number if different to primary support person)	Health Fund No:
	DVA:

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Patient Social Situation	**Specialist Name**
☐Lives Alone ☐Lives with Carer	Name:
☐Residential Care ☐Low Level ☐High Level	Clinic:
***General Practitioner**	Address:
Name:	Phone:
Clinic:	Fax:
Address:	Other Service Providers
Phone:	Details:
Fax:	
Allied Health assessments and Equipment	
☐ Yes ☐ No	

Does the patient have an existing advance care plan / advance care directive or goals of care document?
Yes ☐ If Yes, please attach a copy to this document No ☐

Reason for Referral | Current Issues Please include any information which may be useful as background information to assist with the referral
Patient and family expectations:

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Diagnosis/ Past medical History:

Critical Handover | Information:

Allergies:

Behavioural or cognitive concerns:

* **PLEASE ATTACH THE FOLLOWING RELEVANT INFORMATION TO ALLOW THIS REFERRAL TO PROGRESS (tick items attached)**

- ☐ Discharge Summary
- ☐ Pathology & Radiology Report
- ☐ Equipment Provided
- ☐ Other Relevant Clinical Information
- ☐ Anticipatory Medication Orders
- ☐ Services Arranged or in Place
- ☐ Lung Function Tests
- ☐ EMG /NCS
- ☐ MRI / CT

Signed:

Name:

Designation:

Date:

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