A Division of Royal District Nursing Service
ABN 49 052 188 717
Level 2
1155 Toorak Road
HARTWELL 3124
Phone 1300 633 933 Fax 1300 791 162

Referral Form

☐ HITH ☐ Residential Aged Care ☐ Other (specify)__________________

Referral source ______________________ **Referral date** _____/_____/______
Organisation name ____
Contact person ____
Address ____
________________________________Postcode____________
Phone (Business hours) __________________(Fax)_______________

Client details
Title (Mr, Mrs, Ms) Surname________________First names_______________________
Address ____
Suburb ________________________________Postcode ___________
Phone (Home) ___________________(Mobile)__________________
Birth date ______/______/______
RDNS UR Number ____________________
Interpreter required: **Yes** ☐ **No**☐

Diagnosis
____
____

Care required
____
____
____

Has 1st IV antibiotic dose been given? Yes ☐ No ☐

Medical orders requested Yes ☐
Requested start date ______/______/______End date_____/_____/______
Frequency & time (if required) _______________________________________
HACC/PAC (please circle) date to be organised upon admission. Yes ☐ No ☐
If Yes, date for HACC/PAC is___/______/______RDNS Centre:____________________
Please Note: After hours security check is required for ALL clients needing evening visits or call-out response. PLEASE FAX TO 1300 791 162

Local medical officer / Medical contact details

Name ____

Address ____

Phone (Business hours)____________(After hours)_______________