South West Healthcare

SWH DAY STAY UNIT REFERRAL FORM

URN:	
Family Name:	
Given Name:	
DOB:	Gender:
Residential Address:	
Contact Number:	
COMPLETE ALL FIELDS OR ATTACH PATIENT LABEL	

Interpreter required: Yes ☐ No☐	**Primary Carer:**
Language Spoken:	**Carer Contact Number:**
Medicare No.:	**GP Name:**
Prefix No.:	**GP Address:**
Concession Card No./Expiry:	
Referring Dr:	**Referring Dr Contact Number:**
Referring Dr Specialty:	**Referring Dr Address:**

Please tick the most appropriate Category. To be completed by Referring Dr.

Category 1 (Urgent – Within 7 days) ☐	**Category 2 (Semi-Urgent – Within 30 days)** ☐	**Category 3 (Non-Urgent – Within 90 days)** ☐
Admission desirable for a condition that has the potential to become life-threatening or emergency	Admission desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency	Admission at some time in the future for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency

- Referrals for iron infusions require recent (< 1 months) pathology results (FBE and Fe studies).
- **Incomplete referrals will be returned.**

Principal Diagnosis:	
Medical History:	
Full Medications List (attach list if required)	
Allergies:	
Relevant Investigations / Test Results (Please attach Pathology results)	

- A completed Consent Form, signed by both the Referring Doctor and Patient, is required to be submitted as part of this referral.
- All patients require a valid and current PBS script / BloodNet Authorization.
- For long term/ongoing referrals, a new referral is required every 12 months with any changes or updates to medical history.
- Certain radiological-guided procedures (lung biopsies, intraperitoneal biopsies, pleural drainages, therapeutic lumbar punctures, and ascitic taps) require the completion of this form. The Lumus Radiologist is the Specialist who will decide if a radiological-guided procedure for a patient can be undertaken at SWH.

Infusion ☐	**Procedure** ☐
Treatment:	**Procedure:**
Indication:	
Dose:	**Indication:**
Treatment Frequency: (if applicable)	
Commencement Date:	**Date of Next Outpatient's Review with Referring doctor:**
Final Treatment Date:	
Date of Next Outpatient's Review with Referring doctor:	

Other Comments:

Name of Referring Dr:	**Signature of Referring Dr:**	**Date:**

PLEASE TURN OVER

Please send completed referral form, signed consent form, and all required pathology results to:

SWH Day Stay Unit
Warrnambool Base Hospital
Ryot St, Warrnambool VIC 3280
OR VIA
Email: ward1@swh.net.au **Fax:** (03) 556 44 258

An original copy of the PBS Prescription Script is required to be sent by mail to the DSU. The PBS Prescription cannot be sent to the DSU via fax or email.

HOSPITAL USE ONLY BEYOND THIS POINT
Coordination of the steps below shall be led by the SWH Access Team & DSU

SECTION 1
Date Referral Received:

SECTION 2
Completeness of Referral Received:

Documentation of Treatment / Procedure Yes ☐ No☐	Consent for Treatment/Procedure Yes ☐ No☐
Current PBS Script Yes ☐ No☐ NA☐	Require additional information from referring Dr Yes ☐ No☐

SECTION 3
Does this referral involve a radiologically-guided procedure? Yes ☐ No☐
If Yes, please complete the following the rest of Section 3.
If No, please go to Section 4.

Date of Daily Huddle & Communication with Lumus Team:
Date of Radiologically-guided procedure provided by Lumus Imaging team:
Lumus Imaging (as per Lumus Antithrombotic Guidelines) & SWH Medical Consults Registrar Recommendation Pre-Procedure e.g. anticoagulation use etc.
Are any pathology tests required pre-radiological-guided procedure? Yes ☐ No☐
If Yes to Above, which Pathology tests are required?
Pathology Request Form completed by SWH Medical representative? Yes ☐ No☐
Has Lumus Team communicated SWH Medical Consults Registrar's Recommendation to Patient: Yes ☐ No☐
Date of communication of Medical Recommendation & Pathology Tests to be undertaken, to Patient by Lumus Team:

SECTION 4
Scheduled Admission Date:

SECTION 5
Does this patient require an overnight/multi-day admission? Yes ☐ No☐
If Yes, go to Section 6.
If No, go to Section 7.

SECTION 6

Which AGMU team will be admitting the patient?
Has the Admitting AGMU Physician / Registrar been informed of the scheduled admission? Yes ☐ No☐ **NOTE: The Admitting AGMU team should be provided at least 3 business days' notice of the scheduled admission.**
Is the patient likely to require an overnight admission into SSU following the procedure? Yes ☐ No☐
If Yes to Above, Has the Admitting AGMU Physician / Registrar been informed of the scheduled overnight admission? Yes ☐ No☐
Date of Access Team Notification to AGMU Physician / Registrar:
Name of AGMU Physician / Registrar notified:

SECTION 7
Has Access Team notified Bookings Office of Scheduled Admission Date & Provided all documents? Yes ☐No☐