South West Healthcare

SWH DAY STAY UNIT REQUEST FOR ADMISSION

Incomplete referrals will be returned (please refer to guidelines).

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

GP Name:	Language Spoken:	Interpreter Required: ☐ Yes ☐ No
GP Clinic:	Medicare No.:	Medicare Suffix:
	Concession Card No./Expiry:	
Contact Person:	Relation:	Contact Person Phone:

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

Principal Diagnosis:	
Medical History:	
Allergies:	**Medications:**
Weight:	
Please attach relevant investigations results	

☐ **Infusion**	☐ **Procedure**
Treatment:	**Procedure:**
Indication:	
Dose:	**Indication:**
Treatment Frequency:	
Commencement Date:	
Final Treatment Date: **OR** ☐ **ongoing***	**Radiology Request sent to Lumus?:** ☐Yes ☐ No
Other Comments:	

***For long term/ongoing referrals, a clinical letter will be required after each specialist review.**

- A completed **Consent Form**, signed by both the Referring Doctor and Patient, is required to be submitted for all procedures and administration of blood products (including IVIG). Consent for medications can be completed in the appropriate section on this form (see next page).
- All patients require a valid and current **PBS script / BloodNet Authorization** (send script original by mail).

Referring Doctor:	**Specialty:**	**Date:**
Signature:	**Contact Number/Email:**	**Address:**
Date of Next Outpatient's Review with Referring Doctor*:		

PLEASE SEE NEXT PAGE FOR CONSENT

Please send completed Request for Admission, Clinical Letter, Consent Form (if required), photocopy of Script, and all required Results to:

Day Stay Unit
South West Healthcare
25 Ryot St, Warrnambool
VIC, 3280

Email: vimt@swh.net.au
Fax: (03) 5564 4258

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

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.

Consent for Treatment *Please note: the consent below is NOT valid for blood products (including IVIG). These require a separate form (MR12/11) as per SWH policy. Written consent for procedures will be obtained by the radiologist on day of treatment.*	
I,________DOCTOR________, as treating specialist of patient,________PATIENT________, have discussed the significant risks and complications, benefits, alternatives and goals of the recommended treatment specific to the patient's individual circumstances. The patient has considered these and has provided **verbal consent** for the treatment specified on this form to be completed at South West Healthcare, Warrnambool.	
Risks outlined:	
Signature of Specialist:	**Date:**

HOSPITAL USE ONLY BEYOND THIS POINT

SECTION 1:	Date Referral Received:		
	Date Huddled:		
SECTION 2:	Completeness of Referral: (✓ when complete ✗ if N/A) ☐ RFA ☐ Consent ☐ Script ☐ Clinical Letter ☐ Results ☐ Lumus Request		
	Additional Information required:		
SECTION 3: *Radiology Procedures Only*	Is this request for a Radiology Procedure? ☐ Yes ☐ No *If no, go to section 4*		
	Date & Time of Procedure:		
	Anticoagulant Details:		
	Pathology Request Required? ☐ Yes ☐ No	If yes, specify:	If yes, ordered? ☐
SECTION 4: *Overnight Stays Only*	☐ Day Case *if yes, go to section 5* ☐ Overnight Stay		
	Admission Date:	Length of Stay (Days): ☐ 2 Other:	
	Discussed with Access: ☐	Name:	Date:
	Admitting Ward: ☐ SSU Other:		
	Admitting Team: *If overnight stay, Medical Registrar to be informed of admission prior*	Admitting registrar aware: ☐	
SECTION 5:	Ready for Care? ☐ Date:	Date of Appointment:	
	Documented in Trak? ☐	Scanned & Uploaded to Trak: ☐ Date:	