

MEDICATION AUTHORITY Phone: 8372 4999 Fax: 8372 4900

Surname..... Given Name..... D.O.B.....
 Address.....
 Suburb..... Post Code..... Phone No.....
 Diagnosis..... Allergies.....

PLEASE PRINT CLEARLY

INTRAVENOUS MEDICATIONS

Date	Drug Order	Dose	Route	Freq	Administration Time	Date to Commence	Cease Date	Signature

PICC Insitu: Yes No Date Cannulated: Yes No Date

BLOOD PRODUCTS

Date	Blood Product to be Administered	No of Units	Route	Transfusion Time per Unit	Date to Commence	Cease Date	Signature

Please prescribe flushes including volume and if required diuretics

ORAL, SUBCUTANEOUS, INTRAMUSCULAR & OTHER

Date	Drug Order	Dose	Route	Freq	Administration Time	Date to Commence	Cease Date	Signature

Special Instructions.....
 Doctor's Name..... Signature.....
 Contact Phone No..... Provider No.....

HOME NURSES REFERRAL Phone: 8372 4999 Fax: 8372 4900

Title..... Patient's Surname..... Given Name.....

D.O.B..... Patient's Address.....

Suburb..... Post Code..... Ph..... Mob.....

Postal Address (if different from above).....

Country of Birth..... Medicare Number.....

N.O.K..... Relationship..... Ph.....

FUNDING Health Fund..... Membership Number.....

DVA Gold Work Cover HAS

DVA White Third Party Other (ie. self funded).....

Card Number..... Claim No..... Case Manager.....

Referring Doctor..... Provider Number..... Ph.....

Referring Hospital..... Admission Date..... Discharge Date.....

Hospital UR No..... GP..... Ph.....

DIAGNOSES

Primary.....

Secondary.....

Past History.....

Surgical Procedure (if applicable)..... Date..... DRG.....

Allergies.....

TREATMENT REQUEST (tick appropriate boxes)

- | | | |
|---|--|---|
| <input type="checkbox"/> Monitor vital signs and record | <input type="checkbox"/> Diabetes stabilising and monitoring | <input type="checkbox"/> Continence and/or bowel management |
| <input type="checkbox"/> IV management/Baxter | <input type="checkbox"/> Stomal therapy | <input type="checkbox"/> Wound management |
| <input type="checkbox"/> Pain management | <input type="checkbox"/> Drain management | <input type="checkbox"/> Acute eye management post surgery |
| <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> Medication management | <input type="checkbox"/> Catheter management |
| <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Other (specify)..... | |

SPECIFIC TREATMENT REQUEST.....

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Frequency..... Comm. Date with Home Nurses.....

Medication Authority/Anaphylaxis Protocol attached: Yes No

Existing Services: (please list).....

Other Relevant Information/Hazards/Infections: (dogs, behavioural, MRSA etc).....

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Name of Referrer..... Referrer's Signature..... Position.....

Doctor's Signature..... Provider No..... Date.....