Metropolitan Referral Unit

Government of South Australia
SA Health

Continence Device Change – Hospital Avoidance

Referral Fax 1300 546 104

Referral source ☐ RACF ☐ GP

PATIENT INFO Sticker/MR10/UR No: _____

Surname: _____ First name: _____

Address: _____

Suburb: _____

_____ P/Code: _____

☐ Male ☐ Female DOB: ____/____/____

Telephone: _____

Mobile: _____

Address where care to be provided (if not usual address)

Address: _____

Suburb: _____

Date of referral: ____/____/____ Time: ____/____/____

Requested Service Commencement date: ____/____/____

Referring Facility: _____

Room/ Section: _____

Aged Care Facility: ☐

Phone number for RN in RACF: _____

USUAL LIVING:

☐ Alone ☐ Spouse/Partner

☐ Disability Housing ☐ Other: _____

NOK: _____ (Relationship): _____ GP/Practice: _____

NOK Phone (s): _____ GP Phone: _____

INDIGENOUS STATUS: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown

COUNTRY OF BIRTH: ☐ Australia ☐ Other *(specify)*: _____

Interpreter required? *specify* _____

KNOWN RISKS TO COMMUNITY STAFF VISITING HOME: (Environment/ Aggression/ COVID RISKS)

_____

_____

PRIMARY DIAGNOSIS: _____ _____

_____

PMH & Secondary Conditions: _____

_____

ALLERGIES: _____ MRO: ☐ MRSA ☐ VRE ☐ Other MRO _____

MANAGEMENT PLAN / CARE REQUESTED: (please attach with this form any additional information to assist community care delivery)

☐ IDC ☐ SPC

Date last changed: ____/____/____

Changed by: _____

Size of device: _____

Brand of device: _____

Comments : _____

_____

_____

Do you have a catheter or drainage bag in stock? _____

Referrer's signature: _____	Print Name: _____ Role/Designation: _____ Contact number: _____

Please complete form and FAX to 1300 546 104 or Phone 1300 110 600. Please ensure you confirm we have received your referral for assessment.