Metropolitan Referral Unit - Paediatric Referral Form

Government of South Australia
SA Health

Referral Fax: 1300 546 104 Email: Health.MRU@sa.gov.au

PATIENT INFO Sticker/MR10/UR No:
Surname: First name:
Address:
Suburb: P/Code:
☐ Male ☐ Female DOB: / /
Tel: Mob:
Address where care to be provided (if not usual address)
Address:
Suburb:

Referral source ☐ NALHN ☐ SALHN ☐ WCHN
Date of referral: Time:
Requested service commencement date:
Referring hospital/agency:
Ward/Unit: Ext No:
Admission date: Discharge date:

USUAL LIVING:
☐ With parents ☐ With family/friends
☐ With Carer/Legal Guardian ☐ Other:

NOK: (Relationship):
NOK Phone(s):

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NOK Phone(s):

INDIGENOUS STATUS: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown
COUNTRY OF BIRTH: ☐ Australia ☐ Other *(specify)*:
Interpreter required? *specify*

GP/Practice:
GP Phone:

KNOWN RISKS TO COMMUNITY STAFF VISITING HOME: (Environment /Animals /Aggression/vulnerable child /DCP/CARL involvement)

PRIMARY DIAGNOSIS: (including duration of symptoms):

PMH and secondary conditions:

Gestation at birth: /40

ALLERGIES: MRO ☐ MRSA ☐ VRE ☐ Other MRO *(specify)*:

Respiratory rate: Respiratory distress: SpO_2: Pulse Rate:
Cap. Refill: BP: Temperature: Weight:

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

RESPIRATORY ASSESSMENT ☐ (please complete the following) (AND/OR) HYDRATION ASSESSMENT ☐ (please complete the following)

Respiratory distress/WOB details:

Oxygen requirements:

Usual feeds:
Feeding in hospital:

Additional information/Other Care Requested: (eg wound care, asthma education, midwife visit, medication management)

Date and location of next Outpatient Appt: (if known) or GP follow-up plan:

Attached: ☐ Medication Authority ☐ Asthma Discharge/Action/Recovery Plan(s) ☐ Discharge Summary ☐ Fluid balance
☐ RDR Chart ☐ PICC/Other Vascular line details ☐ Wound Chart ☐ Other information attached:

Community Services and New referrals	**Current/New**	Details - contact name and phone number	Referred Date

Equipment in place (describe):
Equipment requested:

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

Please complete form and send via email Health.MRU@sa.gov.au or FAX to 1300 546 104.
Access and download forms and resources: www.sahealth.sa.gov.au/MRU or Phone 1300 110 600.

SUBMIT