Metropolitan Referral Unit

Continence Device Change – Hospital Avoidance

Government of South Australia
SA Health

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

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 *(specify)*:

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 send via email Health.MRU@sa.gov.au or FAX to 1300 546 104

SUBMIT