



Government of South Australia

SA Health

# VIRTUAL CLINICAL CARE SERVICE REQUEST

(MR-VCC)

Hospital/Site: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex/Gender: .....

## PART A:

To be completed by the Referrer

Date of Referral: ..... Site: .....

Name of Referrer: .....

Phone: ..... Mobile: .....

Fax: ..... Email: .....

### Client Address and Phone Contacts

Address: ..... Postcode: .....

Mobile: ..... Phone: .....

Indigenous Australian Yes  No  CALD: Yes  No

Ethnicity – other: .....

### Clinical Information (if medical summary not attached)

Key reason(s) for referral: .....

Relevant Medical History:  
Eg COPD  
HFrEF  
HFpEF  
T2DM

Action Plan:  Chest Pain  Heart Failure  Asthma  
(Please attach with the referral)  Blood Pressure  COPD  Other:

Visual Impairment: Yes  No  Details: .....

Lives alone: Yes  No  Details: .....

Carer: Yes  No  Details: .....

Hearing Impairment: Yes  No  Details: .....

Fluid Restriction: Yes  No  Details: .....

Current Weight: ..... (kg) Dry Weight: ..... (kg)

### Allergy Details (if known)

Allergy to: .....

Reaction Details: .....

Rescue Medication: .....

### Next of Kin Details

Name: ..... Relationship: .....

Address: .....

Mobile: ..... Phone: .....

### GP Details

GP Name: .....

Practice Name: .....

Address: .....

Phone: ..... Fax: .....

Email: .....





Government of South Australia

SA Health

# VIRTUAL CLINICAL CARE SERVICE REQUEST

(MR-VCC)

Hospital/Site: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex/Gender: .....

## Monitoring Parameters

Limits set by GP:

Limits set by Nurse:

**Note: Please set the vital signs limits**  
(if they are not set the generic limits below will be used until completed parameters are received)

Vital	Lower Limit	Target	Upper Limit
Pulse			
SBP			
DBP			
SpO2			
Glucose			
Weight			
Temperature			

Use Generic Limits Below:

Vital	Lower Limit	Upper Limit
Pulse	60	100
SBP	100	150
DBP	60	90
SpO2	95	
Glucose	4.0	8.0
Weight	Weight will be set using the first weight recorded whilst on VCC	Change 2 kg over 2 days
Temperature		38°C

## Additional Notes or Special Requirements

Form Completed By:

Date:



Government of South Australia

SA Health

# VIRTUAL CLINICAL CARE SERVICE REQUEST

## (MR-VCC)

Hospital/Site: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex/Gender: .....

### Part A: VCC Client Consent Form

To be completed by the Referrer

I, (insert client name) \_\_\_\_\_

agree to participate in this home monitoring program and I understand that I am free to withdraw at any time.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I understand that the monitoring equipment is the property of the Rural Support Service and I agree to return it upon finishing the program.

I agree to complete a feedback questionnaire upon finishing the program.

I give permission for the Virtual Clinical Care Home Tele-Monitoring Service to contact my nominated medical clinic and have access to my current Health Summary and Medication List.

My nominated medical clinic is \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Referrer  
(please print):

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please email or fax completed VCC Service Request and Consent Forms to [VCCHUB@sa.gov.au](mailto:VCCHUB@sa.gov.au)

**Submit**

Email: [VCCHUB@sa.gov.au](mailto:VCCHUB@sa.gov.au)

Fax: (08) 8553 4298

Telephone: 1300 678 182



Government of South Australia

SA Health

## VIRTUAL CLINICAL CARE SERVICE REQUEST

**(MR-VCC)**

Hospital/Site: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex/Gender: .....

<b>PART B:</b>	<b>To be completed by the Virtual Clinical Care Nurse</b>
----------------	---

**Access to Results – GP**

Yes – Monthly Report Required  Yes - Database Access Required

**Access to Results - Nurse or Allied Health Permission**

Surname:		Given Name:	
Workplace Name:			
Address:		Postcode:	
Phone:		Fax:	
Email:			

Yes – Database Access Required  Yes - Monthly Report Required

**Personal Escalation Contact Points**

**First Personal Contact**

Name:		Relationship:	
Mobile:		Phone:	
Availability:			

**Second Personal Contact**  N/A

Name:		Relationship:	
Mobile:		Phone:	
Availability:			


**Clinical Escalation Contact Points**

**First Escalation Point**

Name:		Role:	
Location:			
Mobile:		Phone:	
Email:		Fax:	
Availability:			

**Second Escalation Point**  N/A

Name:		Role:	
Location:			
Mobile:		Phone:	
Email:		Fax:	
Availability:			

 <p><b>VIRTUAL CLINICAL CARE SERVICE REQUEST</b></p> <p style="text-align: center;"><b>(MR-VCC)</b></p> <p>Hospital/Site: .....</p>	<p style="text-align: center;">Affix patient identification label in this box</p> <p>UR No: .....</p> <p>Surname: .....</p> <p>Given Name: .....</p> <p>Second Given Name: .....</p> <p>D.O.B: ..... Sex/Gender: .....</p>
---	--

**Kit Delivery**

<b>New Kit Required:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Use kit already at site (re-assignment):</b> <input type="checkbox"/> Yes <b>Kit Number:</b>
---	--

Kit Delivery Address: .....

Name: .....  
*(staff member expecting kit delivery)*

Does the client use a mobile phone in their home?  Yes  No

**Kit Installation**

**Monitoring Commencement Date:** .....

**Schedule Time:**  0600  0630  0700  0730  0800  0830  0900  0930  1000

*\*Please advise the client that the tablet will start prompts 30 minutes prior to the scheduled interview time*

**Number of days per week to be monitored:**  3(M,W,F)  5(M-F)  7 days

**Days to be monitored:**  Mon  Tues  Wed  Thur  Fri  Sat  Sun

**Interview Type:** *(tick all that apply)*  Heart Failure  COPD  T1DM  T2DM  HTN

**Peripherals:** *(tick all that apply)*  Oximeter  BP  Scales  Glucometer  Thermometer

**Special Request:**  Bariatric Scales *(if weight > 120kg or unsteady and requires a larger platform)*

**BP Cuff Size:** *(tick one)*  Small Cuff = 18-21cm  Medium Cuff = 22-31cm  Large Cuff = 32-45cm

<b>Form Finalised by VCC Nurse:</b> .....	<b>Date:</b> .....
---	--------------------