Macedon Ranges Health

REFERRAL TO MACEDON RANGES HEALTH

Referrer: Please complete and fax to MRH 5428 0399 or post to P.O. Box 588, Gisborne Vic. 3437
Or complete online (Connecting Care, Argus, My Aged Care) and send via Connecting Care, Argus or My Aged Care (over 65)

MRH UR: *(if known)*	
MAC No: *(if Known)*	

CLIENT DETAILS

Date of Referral:		**Date of Birth:**	
Given Name:		**Family Name:**	
Address:			
Home Phone:		**Mobile Phone:**	
Next of Kin:		**Relationship:**	
Home Phone:		**Mobile Phone:**	
Interpreter required:	☐ No ☐ Yes	**Language Spoken at Home:**	
Diagnoses:			
Relevant past history:			
Allergies:			
Pension / DVA Number: *(if applicable)*			
Client is aware of referral:	☐ Yes ☐ No		
GP details: ***(if not referrer)***	Name:		
	Address:		
	Phone:	Fax:	
Funding:	☐ Private	☐ CHSP	

REFERRER DETAILS *(COMPLETE AS REQUIRED)*

- **The information has been faxed/phoned:** ☐ Yes ☐ No

Hospital / Clinic:			
Ward / Unit:			
Contact Person:			
Phone:		**Fax:**	
Planned discharge date:		**Requested first visit:**	
GP / Hospital DVA Provider No.: *(this is NOT the client's VX number)*			
Days you usually visit the client: *(Community referrers)*			

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MRH SERVICES / CARE REQUESTED *(TICK AS MANY AS REQUIRED)*

HEALTH SERVICES			
☐ Counselling	☐ Diabetes Education	☐ Dietetics	☐ District Nursing
☐ Exercise Physiologist	☐ Home Care (Private)	☐ Lifestyle Enhancement Program (LEP)	☐ Occupational Therapy
☐ Physiotherapy	☐ Podiatry	☐ Psychology	☐ Speech Pathology
☐ Other, please state			
☐ Provide additional details for Services			

Additional Information: *If you have requested an invasive procedure (eg. IV Therapy, Catheter M/ment, Wound care) please include or attach **medical authorisation** with specific details (eg. type and size catheter, specific wound regime). Please include information about infections (eg. MRSA/VRE).*

List of Medications to be attached.	
☐ Required equipment has been provided	
☐ I have included / attached medical authorisation	

OTHER RELEVANT INFORMATION

REFERRER

Name: *(please print)*			
Signature:		**Date:**	