Patient Referral Form

Lady Davidson PRIVATE HOSPITAL by Healthscope

Enquiries and referrals **P** 02 9488 0189 /02 9488 0109 **F** 02 9488 0151 **E** ldhreferral@healthscope.com.au

Patient Details

First Name:	**Surname:**
Date of birth: / /	**Gender:** Male ☐ Female ☐
Address:	
	Postcode:
Country of birth:	**Phone number/Mobile:**
Medicare number:	**Ref:** / **Medicare expiry:**
Full name of carer/ next of kin:	**Contact number of carer/ next of kin:**
Does the patient have Private Health Insurance/DVA card? (please circle)	**YES** **NO**
Insurer details:	**Insurance number:**
Is the patient currently in hospital? (please circle) **YES** **NO** **If yes, please provide name of hospital and date of admission**	
Has the patient been admitted to another health care facility in past 28 days? (please circle) **YES** **NO** **If yes, please provide dates of ALL admissions and discharges**	
Referral type (please circle) **Inpatient program** **Day program**	
Has the patient given permission for this referral to be made? (please circle) **YES** **NO**	
DIAGNOSIS:	
Weight:	**Infectious status:**
Diet:	**Allergies:**
Mobility: **Premorbid:** **Current:**	**ADL's:** **Premorbid:** **Current:**

Referring Doctor details

Referring Clinician:	**Referring Doctor:**	**Provider number:**
Referring hospital /practice name:		
Clinic contact number:	**Clinic fax number:**	
Admission date to this facility/clinic/hospital:	**Requested admission date to Lady Davidson:**	
General Practitioner (if different to referring doctor) **GP full name:** **GP address:**		
GP contact number:	**GP fax number:**	

Clinical documents (please attach all available)

Front page / Demographic page	**GP Health summary**	**Clinical notes** (eg: physio etc)
Recent discharge summary from hospital	**Medication list**	**Relevant investigations**