Epworth

# HOSPITAL IN THE HOME REFERRAL CHECKLIST

*Affix Patient Identification Label*

Unit Record Number .....

Surname .....

Given name .....

D.O.B. ..... Age ..... Sex.....

Medical Practitioner .....

**Fax to HHU on 9426 6856 or email to hith@epworth.org.au**

Patient's name: DOB:

Address:

Health Fund:

Hospital: Ward: Room: Contact Phone:

Diagnosis:

Procedure:

Past History:

Medication Treatment:

Length of Treatment:

Referring Specialist:

Other mobility/social limitations/care needs with ADL's:

Planned date for transfer home and to Hospital in the Home:

Appointments already arranged:

Date of Referral:

** ATTACH Drug chart to referral

After receiving this referral, a Hospital in the Home doctor will review the patient prior to accepting the patient. This is usually done within 24 hours of receipt of referral.

Transfer to Hospital in the Home is subject to health fund eligibility.

Contact us:
Phone: **0407 530 954**
Email: **hith@epworth.org.au**

REF2H

08/22

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