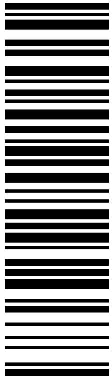
Health
Northern Sydney
Local Health District

Facility: COM HKH MQE MVH RNS RYD



COR5189

MEDICAL DAY PROCEDURES UNIT REFERRAL

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. DD / MM / YYYY	M.O.
ADDRESS	
	PH
M/C	FIN
LOCATION / WARD	ADM DD / MM / YYYY

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Name .... Signature ....

Date of referral: __ / __ / ____

Patient Details

Diagnosis:

Medical history and social information:

Attending for:

☐ Infusion Infusion type .... Dosage ....

Frequency .... Duration ....

☐ Biopsy .... ☐ Procedure ....

Category: ☐ Rapid (within 2 weeks) ☐ Urgent (within 4 weeks)

Expected impact on patient if treatment not received: (describe)

Medication chart:	☐ Attached	☐ Not required	BloodStar authorisation:	☐ Completed	☐ Not required
Consent form:	☐ Attached	☐ Not required	Fluid order:	☐ Attached	☐ Not required
Patient with script:	☐ Yes	☐ Not required			
Mobility status:	☐ Ambulant	☐ Non ambulant	☐ Attending with Carer	☐ Care plan attached	

Other special care requirements:

Other relevant information:

Nursing Staff to Complete

Clinical acceptance criteria met: ☐ Yes ☐ No

Comments:

Approved by:

Name .... Signature ....

Designation .... Date: __/__/____

Appointment (administration staff to complete)

Booking made: ☐ Yes ☐ No By .... Date: __ / __ / ____

Appointment date: __ / __ / ____ Time: __ : __

Patient informed and given appointment card: ☐ Yes ☐ No Date: __ / __ / ____

The referral form must be completed fully and triaged by the Hospital team prior to bookings being made. A completed paper medication chart will be required for all infusions and this should be attached to the referral. If any medications need a prescription then please send this to the pharmacy.

Holes punched as per AS2828 - 2012

BINDING MARGIN – NO WRITING

AUG19/V2

CATALOGUE NUMBER NS12243-E

REFERRAL – MEDICAL DAY PROCEDURE UNIT

MARGIN – NO WRITING