ST VINCENT'S PRIVATE HOSPITAL
BRISBANE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

Patient Name:
Patient DOB:
Patient URN:

Alternatively, please affix patient label.

REQUEST FOR ADMISSION TO ST VINCENT'S

please do not write in the binding margin

Telephone: 07 3240 1213 Fax to: 07 3319 5591

Infusion referral

Patient details:

Name: **Sex:**

Address:

DOB: .....

Contact details:

Health fund: Member Number:

Medicare: Ref: Exp:

Intended treatment: Ketamine ☐ Lignocaine ☐ Other Infusion ☐

Supportive Care Only ☐ (please specify)

If other, please give details:

Requested admission date:

Expected length of stay (Number of nights/number of infusions):

Diagnosis (this cannot be ketamine infusion/lignocaine infusion**):**

Specialist letter attached: ☐ Yes ☐ No
If no, please provide letter prior to date of admission.

Is this a coordinated admission with theatre: ☐ Yes ☐ No

If Yes, please specify: ☐ OT ☐ Ward or Radiology

If yes, please specify procedure date.

Allied Health Input required: Group OT and Physio ☐ Individual OT and Physio ☐
If Individual, Please Specify:

Special requirements (i.e. fridge, air mattress, service dog):

Dietary requirements:

Other alerts (ie behavior, trauma, anything that required deviation from normal practices:

NOK DETAILS: **CONTACT NUMBER:**

Referring specialist:

SVPHB02 1020

Once completed, please email referral form to SVHB Admissions Mail svhbadmissions@svha.org.au

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Lock and Submit Form

Clear Form (both sides)

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