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

Diagnosis: **Medical Referral**

Patient Details: Please attach Demographic sheet with Patient details.

Presenting complaint:

Outstanding medical issues (plan and follow up):

Is the patient:

An Orthopaedic patient: ☐ Yes ☐ No (If yes, please attach weight bear status and next review date)

A patient with wounds: ☐ Yes ☐ No (If yes, please attach wound and or Vac management plan and next review date)

Follow up:

Does the patient need any follow up appointments/ Outpatient appointments?

☐ Yes ☐ No (If yes please ensue that these have been booked and provide the details of these appointments/OPD including dates and times)

Does the patient need any procedures or Investigations?

☐ Yes ☐ No (If yes please ensue that these have been booked and provide these details)

Comprehensive Discharge summary Attached: ☐ Yes ☐ No

Is there an Enduring Power of Attorney? ☐ Yes ☐ No ☐ N/K ☐ Copy sighted
If yes, please give details of nominated person & attach copy

Advanced Health Directive: ☐ Yes ☐ No ☐ N/K

Is the patient on antibiotics: ☐ Yes ☐ No (If yes, please include length of time and step down plan)

Is the patient on OR been on Antithrombotic therapy ☐ Yes ☐ No (If yes, please include length of time and step down plan)

1/52 pathology results attached: ☐ Yes ☐ No

Is there any follow up needed: ☐ Yes ☐ No

If yes,

Have there been any clinical Incidents with the patient (met calls/behavior etc) ☐ Yes ☐ No

If yes, please provide documentation

Does the patient have a Multi- resistant organism ☐ Yes ☐ No

If yes, please provide documentation

Other patient concerns (e.g. wandering/dementia/aggression/falls/communication) ☐ Yes ☐ No

Discharge medication list attached ☐ Yes ☐ No

Are there any cognition concerns : ☐ Yes ☐ No

If yes, Please attach MoCA

Does the patient have any previous psychiatric history: ☐ Yes ☐ No

If yes, please attach documentation

Is the patient immunocompromised? ☐ Yes ☐ No

Is the patient's weight >150kg? ☐ Yes ☐ No Patient's weight?

G.P. Name: **Practice:**

Funding Details:

☐ Private Fund:	Membership Number:		
☐ Pensioner	Pension No:		
☐ DVA DVA number:		DVA Gold ☐	DVA White ☐
☐ WorkCover / Third Party			
Medicare No: Ref:	Valid to:	Safety Net Number:	

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SVPHB02 1020

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

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