Queensland Government

West Moreton

# Hospital in the Home Patient Referral

Facility:…………………………………………….

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Verbal or written consent ***has / has not been*** obtained for the referral to the Hospital in the Home.

## Request from:

Referrer Name:__________________________________________ Phone/pager:____________________________________

Ward/Location: ________________________________________ ***Date:*** ______________________________________

## Reason for referral (service required) …………………………………………………………………………………

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Relevant clinical history:………………………………………………………………………………………………

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*Further information can be documented on page 2.*

## Referral process

☐ **CONTACT HITH COORDINATOR FOR ALL REFERRALS EXCEPT DAY INFUSIONS ON 0407 386 692 ( 07:00 – 19:00) (this ensures service has capacity to provide care required)**

**All patients excluding wound care only and day infusion**

- ☐ Patient accepted by HITH Consultant 0418 177 831 (8:30 – 16:30 Mon – Fri**)**
- ☐ Electronic Discharge Summary commenced (in draft form)
- ☐ Discharge medication reconciliation completed on ieMR
- ☐ Chart Medications to be administered by HITH on MAR (all other medications to be suspended)
- ☐ **DO NOT DISCHARGE PATIENT ON HBCIS**

**Day Infusion patients**

- ☐ Ensure referral form has been received – patient does not need to remain inpatient on HBCIS
- ☐ **NO PHONE CONTACT REQUIRED – HITH WILL CONTACT REFER IF REQUIRED**

**Complex wound care when no alternative is available – (clinic based service only)**

- ☐ Contact HITH Coordinator
- ☐ Ensure referral form has been received – patient does not need to remain inpatient on HBCIS
- ☐ Ensure wound care plan is documented on ioeMR unless Vacuum Dressing

**PLEASE SEND REQUEST TO FAX (07) 3413 7474**

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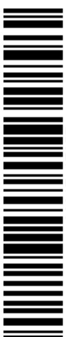
V3.00 05/2020



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Queensland Government

# Hospital in the Home Patient Referral Form

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

**FURTHER REFERRAL INFORMATION:** *(e.g. Medication dose, route, allergies, expected duration, and plan of care)*

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