West Moreton

MeCare
Patient Referral Form

Facility:…………………………………………..….

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐

CONTACT MECARE FOR ALL REFERRALS 1300 632 273 (ext 6180) (8:30 – 16:30hrs)

Request from: ☐ Nursing ☐ Medical Officer ☐

Other:_______________________________________

Referrer: Name: ____ Phone / pager: __________________

Service / Location: ____ ***Date:***_____/_____/________

Selection Criteria: Patient's must fit into the following criteria:

- **Have one or more of the following; heart failure, diabetes, COPD/Asthma and chronic kidney disease.**
- **Resident within the WMH geographic area.**
- **Have at least 3G connectivity at their homes.**
- **Does the patient have stable mental health (ie not actively psychotic or undergoing significant medication regime changes)?** ☐ **YES** ☐ **NO**
- **Is the patient a current user of illicit substances?** ☐ **YES** ☐ **NO**
- **If yes, what substance?** ____
- **Does the patient have a history of admission to WMH hospital greater than 3 times a year for the last 2 years?** ☐ **YES** ☐ **NO**

Reason for Referral: (service required)

Further information can be documented on page 2

THE PATIENT WILL REMAIN UNDER THE REFERRING TEAM UNTIL REFERRAL HAS BEEN ACCEPTED BY MECARE.

Please send request to Fax 3413 5699

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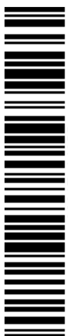
V2.00 08/2018



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

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Please send request to Fax 3813 6116