

Acute Demand Coordination Service

REFERRAL FORM

FAX: 0800 111 994 (v2.1)

Fax to Acute Demand Coordination Service following initial consultation

Surname	First Name	DOB	M/F
Address		Suburb	
Ethnicity	NHI	Phone	
<input type="checkbox"/> Action Needed - Phone Co-ordination Centre on 0800 111 900			
<input type="checkbox"/> Action Taken in Practice - Fax claim through Co-ordination Centre on 0800 111 994			
DIAGNOSTICS Radiology: <input type="checkbox"/> X-Ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> ECG Pathology: <input type="checkbox"/> Serum Troponin <input type="checkbox"/> D-Dimer		Provisional/Working Diagnosis:	
PACKAGES OF CARE MEDICAL/NURSING <input type="checkbox"/> GP practice-based consultation(s) <input type="checkbox"/> GP home consultation(s) <input type="checkbox"/> After hours GP consultation(s) <input type="checkbox"/> PN home consultation(s) <input type="checkbox"/> PN practice-based consultation(s) <input type="checkbox"/> Practice based observation <input type="checkbox"/> Other (specify)..... OTHER <input type="checkbox"/> Domestic Assistance <input type="checkbox"/> Personal care <input type="checkbox"/> Equipment Hire <input type="checkbox"/> Child Care <input type="checkbox"/> Meals <input type="checkbox"/> Shopping <input type="checkbox"/> Transport/Taxi <input type="checkbox"/> Personal Alarm <input type="checkbox"/> Other (specify)..... ACUTE NURSING <input type="checkbox"/> Practice-based consultation(s) <input type="checkbox"/> Home-based consultation(s) <input type="checkbox"/> Other (specify)..... TREATMENTS <input type="checkbox"/> IV therapy <input type="checkbox"/> Cellulitis kit <input type="checkbox"/> Catheter kit <input type="checkbox"/> Other (specify)..... OBSERVATION <input type="checkbox"/> 24hr Surgery Obs Unit		Clinical Information: (Attach summary of consultation notes and other clinical problems) Relevant medical history:	
Recent Hospital Discharge Information: Hospital: Referring Hospital Doctor: Dx Date:		Social Situation <input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Family <input type="checkbox"/> In Rest Home (hospital level excluded)	
		Allergies:	
		Current/Recent Medications:	
GP Name:			
Signature:			
Practice Name:		Phone Number:	
Name of Person Completing Form:		Date:	Time:
FOR OFFICE USE ONLY			
Case Ref #			

When this episode of care is concluded, complete the **CLAIM FORM** and fax to
Acute Demand Coordination Service
Ph 0800 111 900 | Fax 0800 111 994