Metropolitan Referral Unit

Continence Device Change – Hospital Avoidance

Government of South Australia
SA Health

Referral Fax: 1300 546 104 Email: Health.MRU@sa.gov.au

Referral source ☐ RACF ☐ GP

PATIENT INFO Sticker/MR10/UR No: .....

Surname: ..... First name: .....

Address: .....

Suburb: ..... P/Code: .....

☐ Male ☐ Female DOB: ..... / ..... / .....

Telephone: .....

Mobile: .....

Address where care to be provided (if not usual address)

Address: .....

Suburb: .....

Date of referral: ..... / ..... / ..... Time: .....

Requested Service Commencement date: ..... / ..... / .....

Referring Facility: .....

Room/ Section: .....

Aged Care Facility: ☐

Phone number for RN in RACF: .....

USUAL LIVING:

☐ Alone ☐ Spouse/Partner

☐ Disability Housing ☐ Other: .....

NOK: ..... (Relationship): ..... GP/Practice: .....

NOK Phone(s): ..... GP Phone: .....

INDIGENOUS STATUS: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown

COUNTRY OF BIRTH: ☐ Australia ☐ Other *(specify)*: ..... Interpreter required? *specify* .....

KNOWN RISKS TO COMMUNITY STAFF VISITING HOME: (Environment/ Aggression/ COVID RISKS)

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PRIMARY DIAGNOSIS: .....

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PMH & Secondary Conditions: .....

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ALLERGIES: ..... MRO: ☐ MRSA ☐ VRE ☐ Other MRO *(specify)*: .....

MANAGEMENT PLAN / CARE REQUESTED: (please attach with this form any additional information to assist community care delivery)

☐ IDC ☐ SPC

Date last changed: ..... / ..... / .....

Changed by: .....

Size of device: .....

Brand of device: .....

Comments: .....

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Do you have a catheter or drainage bag in stock? .....

Referrer's signature:	Print Name: .....
.....	Role/Designation: ..... Contact number: .....

Please complete form and send via email Health.MRU@sa.gov.au or FAX to 1300 546 104