Metropolitan Referral Unit
Referral Fax 1300 546 104

Government of South Australia
SA Health

Referral source ☐ Public hospital ☐ Mental Health ☐ GP ☐ Aged care facility ☐ Other

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 Hospital/ Agency: _____

Ward/Unit: _____ Ext No: _____

Admission date: ___/___/___ Discharge date: ___/___/___

Aged Care Facility: ☐ Low level ☐ High Level

USUAL LIVING:

☐ Alone ☐ With Family/Spouse

☐ Homeless ☐ Friend/s ☐ 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* _____

DVA Card Holder ☐ Yes ☐ No (DVA number) _____ **Health Fund** ☐ Yes ☐ No

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

_____

_____

PRIMARY DIAGNOSIS: (including date of surgery if applicable): _____

_____

PMH & Secondary Conditions: _____

_____

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

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

_____

_____

_____

_____

_____

_____

Date and location of next Outpatient Appt: (if known): _____

ATTACHED: ☐ Medication Authority ☐ Mental Health Risk Assessment ☐ Discharge Summary ☐ Wound Chart

☐ PICC/Other Vascular line details Other information attached: _____

COMMUNITY SERVICES & New referrals	**Current/New**	Details – contact name & phone number	Referred Date

EQUIPMENT In Place (describe): _____

EQUIPMENT Requested: _____

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

Please complete form and FAX to 1300 546 104 **Access and download forms and resources: www.sahealth.sa.gov.au/MRU or Phone 1300 110 600**