Metropolitan Referral Unit - Paediatric Referral Form

Government of South Australia
SA Health

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

PATIENT INFO Sticker/MR10/UR No: .....
Surname: ..... First name: .....
Address: .....
Suburb: ..... P/Code: .....
☐ Male ☐ Female DOB: ..... / ..... / .....
Tel: ..... Mob: .....
Address where care to be provided (if not usual address)
Address: .....
Suburb: .....

Referral source ☐ NALHN ☐ SALHN ☐ WCHN
Date of referral: ..... / ..... / ..... Time: .....
Requested service commencement date: ..... / ..... / .....
Referring hospital/agency: .....
Ward/Unit: ..... Ext No: .....
Admission date: ..... / ..... / ..... Discharge date: ..... / ..... / .....

USUAL LIVING:
☐ With parents ☐ With family/friends
☐ With Carer/Legal Guardian ☐ Other: .....

NOK: ..... (Relationship): ..... NOK: ..... (Relationship): .....
NOK Phone(s): ..... NOK Phone(s): .....
INDIGENOUS STATUS: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown
COUNTRY OF BIRTH: ☐ Australia ☐ Other *(specify)*: ..... GP/Practice: .....
Interpreter required? *specify* ..... GP Phone: .....
KNOWN RISKS TO COMMUNITY STAFF VISITING HOME: (Environment /Animals /Aggression/vulnerable child /DCP/CARL involvement)
.....
PRIMARY DIAGNOSIS: (including duration of symptoms): .....
.....
PMH and secondary conditions: .....
..... Gestation at birth: ..... /40
ALLERGIES: ..... MRO ☐ MRSA ☐ VRE ☐ Other MRO *(specify)*: .....

Respiratory rate: ..... Respiratory distress: ..... SpO_2: ..... Pulse Rate: .....
Cap. Refill: ..... BP: ..... Temperature: ..... Weight: .....

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

RESPIRATORY ASSESSMENT ☐ (please complete the following) (AND/OR) HYDRATION ASSESSMENT ☐ (please complete the following)
Respiratory distress/WOB details: .....
.....
Oxygen requirements: .....
Usual feeds: .....
Feeding in hospital: .....
.....

Additional information/Other Care Requested: (eg wound care, asthma education, midwife visit, medication management)
.....
.....
.....
.....

Date and location of next Outpatient Appt: (if known) or GP follow-up plan:

Attached: ☐ Medication Authority ☐ Asthma Discharge/Action/Recovery Plan(s) ☐ Discharge Summary ☐ Fluid balance
☐ RDR Chart ☐ PICC/Other Vascular line details ☐ Wound Chart ☐ Other information attached:

Community Services and New referrals	**Current/New**	Details - contact name and phone number	Referred Date

Equipment in place (describe): .....
Equipment requested: .....

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.
Access and download forms and resources: www.sahealth.sa.gov.au/MRU or Phone 1300 110 600.