Silver Chain

POST ACUTE REFERRAL

DOB	PID Number
Gender	
Title / Surname	
Given Names	
Address	
(Type or affix sticker)	

AVAILABLE 24 HOURS A DAY 7 DAYS A WEEK

Telephone (08) 9242 0347 to confirm acceptance prior to faxing on 1300 601 788.
Please fax all referrals individually.

CLIENT DETAILS (attach label if applicable)	1st Visit Date: 1st Visit Time:
Full Name:	
Address:	
Telephone:	Date of Birth:
Email:	
Medicare Number:	URN:
Next of Kin/Carer Name:	NOK Telephone:
Relevant Medical, Surgical and Social History	

REFERRAL DETAILS		
Diagnosis:		Date:
Treatment/Care Plan (Treatment, Expected Duration and Follow-up Required)		
Has the first dose been given?	☐ Yes ☐ No	Time Given:
Is the Client on Warfarin?	☐ Yes ☐ No	Dosage in mg (last given):
PICC Line Details: Type		
External Length:	Certified to Use: ☐ Yes ☐ No	

MEDICAL PRACTITIONERS	
Consultant Name:	Contact Number:
Doctor Responsible for Medical Governance: Contact Number (24/7):	
Current GP Details: Name:	Telephone:

REFERRER DETAILS (Person completing the form)	
Name:	Hospital:
Telephone:	Ward:

DO NOT WRITE IN THIS BINDING MARGIN

All clinical forms creation and amendments must be conducted through the documentation control process

POST ACUTE REFERRAL

CR 10

DOB		PID Number
Gender		
Title	Surname	
Given Names		
Address		
(Type or affix sticker)		

Post Acute Referral

CLIENT DETAILS (attach client label above OR provide 3 identifiers)	
Full Name:	Date of Birth:
Address:	

ALLERGIES

MEDICATIONS														
Date	Medication (Please Print) Tick if variable dose ☐			Time										
Route	Dose	Frequency		Time										
Prescriber Signature:		Print Name:			Prescriber No:									
Date	Medication (Please Print) Tick if variable dose ☐			Time										
Route	Dose	Frequency		Time										
Prescriber Signature:		Print Name:			Prescriber No:									
Date	Medication (Please Print) Tick if variable dose ☐			Time										
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