

## TRANSFER OF MEDICAL CARE

Referral Details			
Referral from Dr. ....	Referral to Dr. ....		
Practice Address: .....	Practice Address: .....		
Phone: .....	Phone: .....		
Fax: .....	Fax: .....		
Email: .....	Email: .....		
Reason for Referral/Admission			
Patient Personal Details			
Name: .....	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	Length of Time with Practice: ... yrs	
Address: .....		MRN: .....	
Marital Status: M <input type="checkbox"/> W <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/>	Spouse/Partner: .....		
Date of Birth: .....	Medicare No. ....	Expiry Date: .....	
Country of Birth: .....	Pension No. ....	DVA No. ....	
Religion: .....	Language Spoken: .....	Interpreter: No <input type="checkbox"/> Yes <input type="checkbox"/>	
Key Family Member/Person Responsible/Guardian/Power of Attorney			
Name: .....	Relationship: .....	Guardian <input type="checkbox"/>	POA <input type="checkbox"/> - Enduring <input type="checkbox"/>
Address: .....	Ph: .....	(H) .....	(W) ..... (M) .....
Name: .....	Relationship: .....	Guardian <input type="checkbox"/>	POA <input type="checkbox"/> - Enduring <input type="checkbox"/>
Address: .....	Ph: .....	(H) .....	(W) ..... (M) .....
Principal Medical Diagnoses	Other Significant Health Problems		
Relevant Medical/Surgical History			
Infectious diseases: No <input type="checkbox"/> Yes <input type="checkbox"/> (give details)			

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<b>Lifestyle Choices</b>		
<b>Smoker</b>	No <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Yes <input type="checkbox"/>	Years smoked ..... Amount/day .....
<b>Alcohol</b>	No <input type="checkbox"/> Yes <input type="checkbox"/>	Standard drinks/day .....
<b>Immunisation Status</b>		
<b>Influenza:</b> No <input type="checkbox"/> Yes <input type="checkbox"/> - date immunised .....		<b>Pneumococcus:</b> No <input type="checkbox"/> Yes <input type="checkbox"/> - date immunised .....
<b>Allergies / Reactions – Medications and Other</b>		
<b>Current Medications / Complementary Therapies</b>		
Authority medications? <input type="checkbox"/>	Date commenced .....	Date last script written .....
On Schedule 8 medications? <input type="checkbox"/>	Safe to self medicate? <input type="checkbox"/> - Bottles/boxes <input type="checkbox"/>	Multidose package <input type="checkbox"/>
<b>Recent Physical Examination / Investigations / Specialist Reports</b> (attach copies of reports)		
<b>Behaviours/Psychological Symptoms of Dementia</b>	<b>MMSE</b> .....	
<b>Other Services Involved</b> (past & present e.g. podiatry)		
<b>Advance Care Directive</b>		
Does the patient have an advanced care directive? Yes <input type="checkbox"/> (provide copy) - Last reviewed ..... No <input type="checkbox"/>		
In the event of a cardiac arrest does the patient want to be resuscitated? Yes <input type="checkbox"/> No <input type="checkbox"/>		
The above has been discussed with: Resident <input type="checkbox"/> Person responsible <input type="checkbox"/> Power of Attorney <input type="checkbox"/>		
<b>Consent</b>		
I, ..... (patient/person responsible) consent to the release of my/my relative's relevant personal health information from my GP to the referring doctor and/or residential aged care facility of my choice. I acknowledge that this information will be used for the purposes of assessing my care needs and for the provision of ongoing comprehensive health care. I understand that all information obtained will be kept confidential and that the information contained on this form will not be disclosed to any other individual or organisation (unless they are directly related to my care) without my consent.		
Patient/person Responsible Signature: ..... Print: ..... Date: .....		
<b>Completed by Doctor:</b>	<b>Print:</b>	<b>Date:</b>