PO Box 72, Elwood, Vic 3184
Mob: 0409 545 705
metrowoundcare@gmail.com

# METRO WOUND CARE

CARE COMES HOME

## REFERRAL FORM

| | | | |
|---|---|---|---|
| Date of Referral: | | | |
| **Patient Information** | | | |
| Patient Name: | | | Date of Birth: |
| Address where care to be attended: | | | Phone: |
| | | | |
| Emergency/ NOK*: | Relationship: | | Phone: |
| *Medicare #: | * Ref #: 1 | Expiry: | |
| **Supporting/Referring Medical Specialist** | | | |
| Name of Specialist | | Telephone: | |
| Name of GP: | | Telephone: | |
| **Date and Type of Surgical procedure / diagnosis** | | | |
| | | | |
| **Care request – frequency, dressing plan.** | | **Date of commencement*:** | |
| | | | |
| **Financial responsibility – fee agreement consent form must also accompany this referral** | | | |
| Who is financially responsible for the fees for services provided by Metro Wound Care? | | | |
| Hospital/ward: | # visits: | Invoicing contact: | |
| Patient: ☐ | Financial consent signed and attached to this referral form ☐ | | |
| If private health fund or other third party please attach letter of approval from the provider. | | | |
| **Patient/legal guardian consent** | | | |
| This referral and the associated financial commitments have been explained to me. I consent to the care described being delivered in the location indicated above. | | | |
| **Name:** | **Patient sign**: | **Date:** | |
| **Person completing this referral** | | | |
| **Name:** | **Designation:** | **Sign:** | **PH:** |
| **Checklist** | | | |
| Referral completed **in full** | | | |
| Patient has signed consent for home visit – ensure correct address. | | | |
| Patient has received and signed fee agreement and privacy information. | | | |
| Patient has received contact details for Metro Wound Care | | | |
| **Please attach medical history, medications, wound charts if available.** | | | |

Email to: metrowoundcare@gmail.com or Fax: +6144279044 **Confirm receipt by calling 0409 545 705**