

WACHS Kalgoorlie Health Service

**Hospital in the Home
Hospital in the Nursing Home
Referral**

To be completed by referring medical officer or nurse.

Doctor: _____
 Referral Source _____
 Date of Admission _____
 Date of Admission to H@H _____
Date of 1st HITH Visit _____
Date of Medical Review ___/___/___ Time _____
 Review with _____
 Location of Review _____

GENERAL PRACTITIONER

Name _____ Telephone _____ Fax _____

ALLERGIES _____

MRSA STATUS: _____

PRINCIPAL DIAGNOSIS /PROCEDURE

HITH ADMISSION DIAGNOSIS

TREATMENT PLAN ON TRANSFER

- Intravenous Antibiotics OD BD _____
- Wound Management _____
- _____
- Other _____

BASE LINE OBSERVATIONS on transfer: T _____ P _____ R _____ BP _____

Please use ID label or block print

SURNAME		UMRN	
GIVEN NAMES		BIRTHDATE	SEX
ADDRESS			POST CODE
Indigenous Status (Please tick) Aboriginal <input type="checkbox"/> Torres Strait Is <input type="checkbox"/> Non aboriginal <input type="checkbox"/> Interpreter required Yes <input type="checkbox"/> No <input type="checkbox"/>			

Patient Phone Number _____
 Mobile/alternate Phone No. _____
 NOK Name and Phone Number _____

Visiting Address if different from label;

Verbal check with patient that address & phone number are correct.



I/We confirm that the HITH Program has been explained and I;

- Understand that leaving the hospital is earlier than would have occurred without the HITH program.
- Agree to cooperate with the HITH program and return to the hospital for medical review if advised.
- Agree to be available at a time specified by the HITH nurse.
- Patients agree to attend HITH Treatment room or the surgery for medical review at a specified time.
- Agree to provide a safe environment for my treatment.
- Agree that care will be transferred to other services in the post acute stage.

Signature PATIENT/CAREGIVER _____ Date _____