

METRO WOUND CARE REFERRAL FORM
SHELLEY McIVOR – NURSE PRACTITIONER

REVISED: 01/06/23

Date of Referral:	Date of first visit by Metro Wound Care:		
Patient Information			
Patient Name:		Date of Birth:	
Address where care to be attended:		Phone:	
		Mobile:	
Emergency contact / NOK:		Phone:	
Medicare #:	Ref #:	Expiry:	UR:
Supporting/Referring Medical Specialist			
Practice Name:			
Name of Specialist		Telephone:	
Practice Address:			
General Practitioner;			
GP Name			
Practice details:		Phone:	Fax:
Date of surgical procedure (if applicable) / details of care requested			
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:	
Private insurer:	Referrer must obtain a letter of approval to accompany this referral.		
Patient:	Financial consent signed and attached to this referral form		
TAC/Workcover:	Referrer must obtain a letter of approval to accompany this referral.		
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:	Print:	
Person completing this referral			
Name:	Designation:	Sign:	PH:
Checklist			
Referral completed <u>in full</u>			
Patient has signed consent for home visit			
Patient has received and signed fee agreement and privacy information.			
Patient has received contact details for Metro Wound Care			