METRO WOUND CARE REFERRAL FORM

SHELLEY MCIVOR – NURSE PRACTITIONER

REVISED: 01/06/23

Date of Referral:			
Patient Information			
Patient Name:			Date of Birth:
Address where care to be attended:			Phone:
			Mobile:
Emergency contact / NOK:			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 – start date, frequency, regimen.			
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**:	**Print:**	
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.