THE BAYS

The Bays Healthcare Group Inc

PATIENT REFERRAL

UR NUMBER _____

SURNAME _____

GIVEN NAME(S) _____

DATE OF BIRTH _____ SEX _____

Please fill in if no Patient label available

TO BE COMPLETED BY TREATING DOCTOR

ADMISSION DETAILS

Name of treating Doctor: .....

Date of operation: ..../..../....

Expected length of stay: ☐ Day case ☐ Overnight ☐ Longer..... nights

HDU required: ☐ Yes ☐ No

Expected item number(s): .....

CLINICAL DETAILS

Provisional diagnosis: .....

Other conditions present: .....

.....

Allergies/sensitivities: .....

.....

VTE prophylaxis: .....

PRE-OPERATIVE INSTRUCTIONS / TESTS REQUESTED

Pathology provider: ☐ Melbourne Pathology ☐ Dorevitch ☐ Other .....

Investigations: ☐ X-ray/ultrasound ☐ ECG ☐ Other .....

Instructions on admission: .....

.....

.....

Drug orders on admission (drug order valid for 24 hours only):

Date	Medicine (print generic name)	Dose	Route	Frequency	Signature	Print Name	Time given by	Time given by

DO NOT WRITE IN MARGIN

CPJUNE2016

PATIENT REFERRAL & CONSENT FOR TREATMENT MR/106