**Metro Wound Care Referral Form**

**Shelley McIvor – Nurse Practitioner**

Revised: 01/06/23

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| 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: | | |  | |
| **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: Letter of approval obtained and attached to this referral | | | | |
| Patient: Financial consent signed and attached to this referral form | | | | |
| TAC/Workcover: Letter of approval obtained and attached to 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 **in full**  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 | | | | |