**Metro Wound Care Referral Form**

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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 visitPatient has received and signed fee agreement and privacy information.Patient has received contact details for Metro Wound Care  |