A picture containing text

Description automatically generated­­

This referral will not be activated until you have contacted HITH and emailed/faxed this referral form

**WALLABY WARD REFERRAL: External COVID Referral Form**

**Please scan and email all referrals to:** [**Wallaby.ward@rch.org.au**](mailto:Wallaby.ward@rch.org.au) **or FAX to 9345 6459**

For telephone enquiries call: (03) 9345 4770 **Date**:­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For referrals after hours, intake assessments will be performed after 8:00am the next day.   
For patients requiring urgent medical care please call 000.

**Please read eligibility criteria prior to referral:** <https://www.rch.org.au/wallaby/COVID-19_resources/>

**Patient Details** *(All fields of the patient details to be completed)*

|  |  |
| --- | --- |
| Patient surname: | Given name: |
| Date of birth: | RCH MRN (if has one): |
| Gender: m Male m Female m Other: | |
| Address: Postcode: | |
| Parent / carer surname: | Parent / carer given name: |
| Mobile number: | At least one alternate number: |
| Medicare number: m Not eligible for Medicare | |
| Usual GP (if known): | |
| Indigenous status: m Aboriginal m Torres Strait Islander m Not Indigenous | |
| Interpreter required: m Yes m No Language: | |

**Referring Doctor Details**

|  |  |
| --- | --- |
| Name: | Provider number: |
| Email address: | |
| Telephone number: | Fax number: |
| Signature: | Date: / / |

Is there DFFH involvement, known physical/verbal aggression or drug/alcohol misuse? m No m Yes (brief details)

|  |
| --- |
|  |

**Clinical Criteria for HITH admission:**

|  |  |  |
| --- | --- | --- |
| MODERATELY UNWELL (HITH-specific definition) | **OR** | MILDLY UNWELL BUT HIGHER RISK |
| **Symptoms** | | **Co-morbidities** |
| m Mild to moderate work of breathing but  maintaining oxygen sats >94% in air | | m Cyanotic heart disease |
| m Chronic lung disease |
| m <2/3 usual intake but no NG/IV fluid needed | | m Immunocompromised |
| m Chest pain | | m Complex neurodisability |
| mOther symptoms: | | m Other: |
| **AND Symptoms:** |
| Date of positive COVID test: / / | | |
| Any other relevant management, medical/social history, special needs, allergies, current medications: | | |