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| Werribee Mercy HospitalCOVID 19 Referral Form |  | **Referral Date:** |

COVID -19 Program contact details

**Fax number for all referrals: 8754 3339 Enquiries ph: 8754 6298**

Service Requested

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| COVID-Positive Home Monitoring Program: □ Sotrovimab Monoclonal Antibody Infusion Clinic: □ |

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| Patient Details |
| Last/Family name: | First name: |
| Previous last name: | Sex: Choose an item. |
| Date of birth: | ATSI status: Choose an item. |
| Address: | Home telephone No.: |
| Suburb: | Mobile number: |
| Postcode: | Email: |
| NOK/Carer: | Preferred contact method: |
| NOK relationship: | Medicare no.: |
| NOK contact no.: | Pensioner/Concession/Health/DVA No.: |
| Interpreter required: [ ]  Yes [ ]  No Specify language: |
| Previous Mercy patient: [ ]  Yes [ ]  No | Mercy UR Number (if known): |
| The patient has agreed to the referral and the sharing of their personal and health information with the health service [ ]  Yes [ ]  No |

Referring Doctor Details

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| --- | --- | --- | --- |
| Referring Doctor: |  | Provider number: |  |
| Practice Name: |  |
| Practice Address: |  |
| Suburb: |  |
| Postcode: |  | Phone No: |  |
| Email: |  | Fax: |  |
| Preferred method of communication: |  |

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| **Patient’s usual GP** (if not the same as referring doctor) |
| Name: |  | Clinic: |  |

Clinical information

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| Allergies: COVID-19 Vaccination Status: |
| Height (cm): Weight (kg): BMI: |
| Date of symptom onset: Date of COVID-19 Test: |

Current medication

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| --- | --- | --- | --- |
| Drug name | Ltd. elapse | Strength | Dose / frequency / special |
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Past medical history

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Relevant social history

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Planned location of administration: Werribee Mercy – COVID-19 Infusion Clinic



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| Doctor’s signature: |  | Date: |  |

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This form constitutes a valid referral to Werribee Mercy Hospital provided all requested details are complete.

#  References

1. <https://www.clinicalguidelines.gov.au/portal/2604/australian-guidelines-clinical-care-people-covid-19>