**For long term/ongoing referrals, please ensure a new referral is sent every 12 months with any changes or updates to medical history.**

**Admission Type:**

Public [ ]  Private [ ]  DVA [ ]  Overseas visitor [ ]  Defence [ ]

CGMS [ ]

Trial of Void [ ]

Portacath flush [ ]

PICC line dressing [ ]

Tysabri [ ]

Infliximab [ ]

Vedolizumab [ ]

Iron infusion [ ]

Venesection and hydration [ ]

Chemotherapy [ ]

[ ]  **Category 3** (Non Urgent)

Admission at some time in the future for

dysfunction or disability, which is unlikely to the potential to become an emergency.

[ ]  **Category 1** (Urgent)

Admission desirable for a condition that has the potential to become life threatening or emergency.

[ ]  **Category 2** (Semi-Urgent)

Admission desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency.

**Interpreter required: Yes** [ ]  **No** [ ]

**Language spoken:** ...........................................................

**Has the patient previously attended WMH? Yes** [ ]  **No** [ ]

**If Yes – Was the patient registered under the same name? Yes** [ ]  **No** [ ]

**Previous name:**

a condition causing minimal or no pain,

deteriorate quickly and which does not have

NO WRITING

Page 1 of 1

**WMH MEDICAL DAY STAY WAITLIST FORM *AD 0160***

BINDING MARGIN - NO WRITING

FMH502200

P1721 V4 05/19

Mercy Health

**Mercy Health**

UR No:

Family Name:

**WMH MEDICAL DAY STAY WAITLIST FORM**

Given Name

DOB:

Sex:

Address:

(if no UR)

COMPLETE ALL FIELDS OR ATTACH PATIENT LABEL

**Primary Carer:** ................................................................

**Contact No.:** ...................................................................

**Medicare No.:** ..................................................................

**Prefix No.:** .......................................................................

**Contact No. (H):** ..............................................................

**(M):** .................................................................................

**Referring Dr: Provider No.:**

**GP Name: Clinic: Contact No.:**

**Referrals for iron infusions require recent (<3 months) pathology results (FBE and Fe studies).**

**Incomplete referrals will be returned.**

**Allergies:**

**Principal Diagnosis:**

**Ambulation Status:** (eg ambulant, wheelchair bound, assist transfers)

**Relevant Past History:**

**Proposed procedure or treatment required:**

Blood product: Specify...............................................

IVIg:

Specify ……………………......

Other: (specify)

**Dose:**

**Frequency:**

**Signed: Date:**

**Please send completed referral with required pathology results and health summary to:**

Medical Day Stay

Werribee Mercy Hospital

300 Princes Hwy Werribee, 3030

Fax: 8754 3535

**Hospital Use only:**

Date placed on Waiting List: Date referral received:

Scheduled admission date: