Werribee Mercy Hospital Hospital in the Home	Mercy Health Care first	**Referral Date:** **Phone:**

Upon completion please **email** this referral to HITHreferrals@mercy.com.au

Patient Details

UR number:		Last/Family name:
First name:		Sex:
Date of birth:		
Address (if no UR):		
Treating Doctor/Unit:	Contact number:	Accepted into HITH: ☐ Yes ☐ No
Referral source:		Referral date to HITH:
Transfer date to HITH:		Expected discharge date of HITH:

TREATMENT PLAN: MEDICAL OFFICER/ RN/RM TO COMPLETE

Admitting diagnoses

Relevant past history

Treatment required

Pathology required (please tick): ☐ Yes ☐ No	Path slip completed: ☐ Yes ☐ No ☐ N/A
Date: Type	Medical review date:

MEDICAL OFFICER

Print name:	Designation:
e-Signature:	Referral date:

NURSING ADMISSION

RMO admission done (please tick): ☐ Yes ☐ No	Safe home risk assessment completed: ☐ Yes ☐ No
Discussed treatment plan with patient and/or carer: ☐ Yes ☐ No	PNMH plan attached ☐ Yes ☐ No ☐ N/A
All necessary equipment organized and sent home with patient where relevant: ☐ Yes ☐ No	
Information booklet and relevant education sheets given to patient: ☐ Yes ☐ No	Understand 24hr access to staff ☐ Yes ☐ No
Pharmacy Notified regarding medication ☐ Yes ☐ No	Medication education given? ☐ Yes ☐ No ☐ N/A

Local Medical Officer:	Phone:	Fax:	Notified: ☐ Yes ☐ No

ADMITTING NURSE

Print name:	Designation:
e-Signature:	Referral date:

Werribee Mercy Hospital Hospital in the Home Consent Form	Mercy Health Care first	**Referral Date:** **Phone:**

Upon completion please **email** this referral to HITHreferrals@mercy.com.au

Patient Details

UR number:	Last/Family name:
First name:	Sex:
Date of birth:	
Address (if no UR):	

CONSENT FOR ADMISSION TO MERCY HOSPITAL IN THE HOME PROGRAM

I, the undersigned, agree to be transferred from the Mercy Hospital to be cared for at home by the HITH program, which I would otherwise need to remain in an inpatient bed for treatment.

I have had the program explained to me in a language I understand.

I, and/or my carer agree to take responsibility for me:

- Taking my oral medication as per instructions from the Doctor/Nurse/Pharmacist.
- Complying with instructions regarding rest, exercise, diet and specify education sheets.
- Keeping drugs, supplies in a safe place, out of reach of children.

Finally I understand that if my social or medical condition changes I may be able to return to the Mercy Hospital under advice from Medical/Nursing staff.

e-Signature of Patient/Carer:..... **Date:** ...../...../.....

INTERPRETER STATEMENT

I have given a sight translation in: ..... (state the patient's language here)
Of the consent form and assisted in the provision of any verbal and written information given to the patient/parent or guardian/ Decision-maker by the clinical.

Name of interpreter: .....

e-Signature: ..... **Date:** ...../...../.....

Upon completion please **email** this referral to HITHreferrals@mercy.com.au