Mercy Health
Care first

Mercy Health

UR No:

Family Name:

Given Name:

MEDICAL DAY STAY REFERRAL FORM

DOB: Sex:

Address:
(if no UR)

COMPLETE ALL FIELDS OR ATTACH PATIENT LABEL

FMH502200

New referral required every 12 months.

Is this referral from outpatient clinic ☐ Yes ☐ No

Has the patient had a recent WMH admission? ☐ Yes ☐ No

Diagnosis: _____

Past History: _____

Allergies: _____

Patient Phone Number: _____

Patient contact person: _____

Relationship: _____ Mobile number: _____

Interpreter required: ☐ Yes ☐ No Language spoken: _____

Ambulation status: ☐ Ambulant ☐ Walking aid ☐ Hoist transfer ☐ Other: ……..

Reason for referral:

☐ Blood product *Specify which product, dose and frequency*	☐ Iron infusion *Please include recent FBE and Fe studies*
☐ IVIg *Specify which product, dose and frequency*	☐ IV medication infusion (monoclonal antibodies) *Specify which product, dose and frequency*
☐ Portacath flush / PICC line dressing	☐ Procedures
☐ Other	

Requested start date:

Referring Dr:	Provider No:	Contact:
GP:	Clinic:	Contact:

Signature: _____ Date: _____

Please mail original form to: Medical Day Stay (MDS)
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:

BINDING MARGIN – NO WRITING

In-house, V5, 01/26

MEDICAL DAY STAY REFERRAL FORM AD 0160