bayside Wound + Stomal Therapy Services

# Referral Form

## Patient Details

First Name: _____ Last Name: _____ D.O.B: _____

Address: _____

Phone: _____ Medicare No: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

## Medical Professional Supporting Referral

GP Name: _____ Specialist Name: _____

Provider #: _____ Provider #: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

**Service Request:** ☐ Inpatient ☐ Outpatient ☐ Wound Care ☐ Stoma Therapy

Date and type of surgical procedure / Stoma Type /Wound Type:

_____

**Care Requested:** ☐ Wound Care ☐ Stoma siting / Stoma education and management

Details:

_____

Requested First Date of Visit: ___/___/___

## Financial Details (must be completed to accept referral)

☐ Patient ☐ DVA (Gold) ☐ Hospital ☐ Other eg. Health Fund/TAC (Third Party written approval must accompany this referral)

Further Details (e.g. Number of funded visits) _____ Funding Contact Person: _____

## Referral Details:

Form Completed By: _____ Hospital/Ward/UR Number: _____

Phone/Fax: _____ Signature: _____

**Complete ALL details**

Contact Bayside Wound and Stoma Therapy Services to confirm the referral has been accepted

Rebecca Rios: 0413 588 210 Karen Wendland: 0418123502 FAX: 03 9592 8808

EMAIL: baysidewoundandstoma.services@gmail.com