Metropolitan Palliative Care Consultancy Service (MPaCCS)

Bethesda health care

RE-REFERRAL FORM

Resident Name: ______________________

Date of Birth: ______________________ ☐ Male ☐ Female

Facility Name: ______________________

Facility Phone Number: ______________________

Facilty Location: ☐ North ☐ South ☐ East

Date of Re-referral: ______________________

Re-referred By: ______________________

Resident aware of re-referral? ☐ Yes ☐ No

Family aware of re-referral? ☐ Yes ☐ No

GP aware of re referral ? ☐ Yes ☐ No

GP Name: ______________________

GP RETAINS CLINICAL RESPONSIBILITY FOR RESIDENT

To re-refer to MPaCCS:

- **call us anytime**
- **email us**
- **fax this form to us**
- **send us a discharge letter***
- **speak to us when we visit your facility.**

Monday to Friday 8am - 4pm

Phone: 9217 1777

Fax: 9217 1788

Email: MPaCCS@bethesda.org.au

Internet (referral forms): www.bethesda.org.au/mpaccs

Additional Comments	optional

Please include any relevant documents if available and convenient to do so.

* if the resident is returning from another location

© Bethesda Health Care 2018