

RAPID RE-REFERRAL

Resident Name: _____

Date of Birth: _____ Male Female

Facility Name: _____

Facility Phone Number: _____

Facility 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