Health
Northern Sydney
Local Health District

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. DD / MM / YYYY	M.O.
ADDRESS	
	PH
M/C	FIN
LOCATION / WARD	ADM DD / MM / YYYY

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Facility: COM HKH MAN MQE MV RNS RYD

ACUTE/POST ACUTE CARE (APAC) GP SHARED CARE REFERRAL LETTER

MED11022

Northern Sector: Ph 1300 732 503 Fax 9887 5518

Date: __ / __ / ____ Date APAC Service to Commence: __ / __ / ____

Doctor ..... Provider No ..... Ph .....

Patient Address ..... Confirmed: ☐ Yes ☐ No

Phone ..... Mobile .....

Patient has verbally consented to management by APAC/GP Shared Care Service: ☐ Yes ☐ No

Presenting Problem and Examination Summary:

Acceptable Vital Sign Parameters: BP ..... HR ..... RR ..... SaO2 ..... Temp .....

Past History:

Allergies:

Current Medications:

Follow-up Appointment Has Been Made For: Date: __ / __ / ____ Time: __ : __

Medication Authority

Serum Creatinine ..... micromol/L Creatinine Clearance ..... mL/min Weight ..... kg Target INR .....

First Dose Administered

Date: __ / __ / ____ Time: __ : __ Location ..... Signature .....

Year:	Date & Month:							
Date:	Medication: (Print Generic Name)							
Route:	Dose Frequency & NOW enter times							
Indication	Pharmacy							
Prescriber's Signature	Print Your name	Contact						
Date:	Medication: (Print Generic Name)							
Route:	Dose Frequency & NOW enter times							
Indication	Pharmacy							
Prescriber's Signature	Print Your Name	Contact						
	Pharmaceutical Review:							

Please fax this form to 9887 5518 **(Not a valid order unless legible)**

Name ..... Signature .....

Designation ..... Date: __ / __ / ____