rthealth FUND

hospital at home

Complete this form to enrol in the hospital at home program

Signing this consent shows your interest in participating in the program and authorises rt health fund to obtain information from your doctor, hospital and other relevant health care professionals, and to coordinate services under the hospital at home program on your behalf.

Your details

rt membership number

Given names

Family name

Date of birth (dd/mm/yy)

Home telephone number

Work telephone number

Mobile telephone number

Hospital and treatment details

Treating doctor or GP

Telephone

Expected date of admission (if hospital procedure is already booked)

Hospital

Telephone

Description of procedure being undergone in hospital (if known)

Terms and conditions

This program is available to members who hold any hospital cover with rt health fund, whose contribution payments are up to date, and who have served any applicable hospital treatment waiting periods. This program can only be made available to members on receipt of signed program referral and consent forms. If you cease to hold hospital cover with rt health fund during the course of receiving services under this program, access to the program will cease. Services and telephone support provided under this program will be coordinated by a registered nurse or specialist allied health professional as an authorised agent of rt health fund. If you are not sure what sort of care you need, please call your doctor or local hospital. If you think you have a medical or psychiatric emergency, call 000 or go to the nearest hospital. Any information provided by you when applying for or participating in the program remains confidential and will not affect your contribution rates or benefits. Health information used by the providers of services will adhere to the principles contained in the national privacy guidelines. De-identified information may be used for reporting purposes.

Consent to participate

I have read and understood the terms and conditions of participation in the program. I understand that this program is not suitable for all people and that my doctor and/or nursing staff at the hospital will determine whether it is clinically safe and suitable for me. If I am accepted into the program, I authorise rt health fund to assign a program coordinator to coordinate services on my behalf. I authorise my program coordinator to obtain, and provide where necessary to other staff of the program, all medical records from my doctors, the hospital I am admitted to, and any providers of services in the home.

✗

Today's date / /

please sign here

Please fax (along with the doctor or hospital referral form, if you have one) to 1300 887 123

Questions? 1300 886 123

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