

Services requested (subject to hospital at home approval prior to discharge)

Please provide details of the clinical care required by the patient in their home (or attach document)

Clinical care required

Wound care _____ Frequency _____

Consumables/dressings required _____

Personal care _____ Frequency _____

Medication administration _____ Frequency _____

Other possible services

Assisted care facility (name) _____ Duration _____

Maternity options (midwife visits, nappies, home cleaning) _____

Home cleaning (in conjunction with clinical care) _____

Equipment hire (in conjunction with clinical care) _____

Certification (must be signed by a medical officer, discharge planner or registered nurse)

I certify that if this program was not available, the patient would require hospital care for days.

Name _____ Designation _____

X Today's date / /

please sign here

Please fax both pages along with patient's signed consent to

1300 887 123

remember to fax back both pages