HOME GP VISIT Fax Form

1300 HOME GP

FAX TO OFFICE ON (02) 8724-6301 **DATE REQUIRED:______/______/______**

NURSING HOME / HOSTEL NAME:__________________________

ADDRESS:____

DON / SISTER ON DUTY PHONE NO.:_______________________ **AFTER HOURS PHONE NO.:**_________________________

SPECIAL INSTRUCTIONS:____

FIRST PATIENT

GP'S NAME:________________________________ GP'S PHONE NUMBER: _______________________________

PT SURNAME:__________________________ PT FIRST NAME: __________________________ D/O/B: ________

MEDICARE / REPAT CARD NO: __ __ __ __ __ __ __ __ __ __ REF: _______ EXPIRY: ______

LEVEL/FLOOR: ________________ WARD: __________________ SECTION: _________________

KNOWN ALLERGIES: ____

COMPLAINT OF PT: ____

SECOND PATIENT

GP'S NAME:________________________________ GP'S PHONE NUMBER: _______________________________

PT SURNAME:__________________________ PT FIRST NAME: __________________________ D/O/B: ________

MEDICARE / REPAT CARD NO: __ __ __ __ __ __ __ __ __ __ REF: _______ EXPIRY: ______

LEVEL/FLOOR: ________________ WARD: __________________ SECTION: _________________

KNOWN ALLERGIES: ____

COMPLAINT OF PT: ____

THIRD PATIENT

GP'S NAME:________________________________ GP'S PHONE NUMBER: _______________________________

PT SURNAME:__________________________ PT FIRST NAME: __________________________ D/O/B: ________

MEDICARE / REPAT CARD NO: __ __ __ __ __ __ __ __ __ __ REF: _______ EXPIRY: ______

LEVEL/FLOOR: ________________ WARD: __________________ SECTION: _________________

KNOWN ALLERGIES: ____

COMPLAINT OF PT: ____

FOURTH PATIENT

GP'S NAME:________________________________ GP'S PHONE NUMBER: _______________________________

PT SURNAME:__________________________ PT FIRST NAME: __________________________ D/O/B: ________

MEDICARE / REPAT CARD NO: __ __ __ __ __ __ __ __ __ __ REF: _______ EXPIRY: ______

LEVEL/FLOOR: ________________ WARD: __________________ SECTION: _________________

KNOWN ALLERGIES: ____

COMPLAINT OF PT: ____