SYDNEY MEDICAL SERVICE CO-OPERATIVE LIMITED

1300 HOME GP
4663 47

BOOKINGS OPTIONS:
TEL: (02) 8724 6300
FAX: (02) 8724 6301
EMAIL: calls@sydmed.com.au

NAME OF FACILITY: _____

ADDRESS: _____ **DIRECT PH:** _____

PPE AVAILABLE: ☐ **GOWNS** ☐ **GLOVES** ☐ **GOGGLES** ☐ **MASKS** ☐ **ALL**

COVID CHECK FOR DRS: ☐ **FEVER CHECK** ☐ **STAT DEC TO SIGN** ☐ **FLU SHOT EVIDENCE**

ANY COVID POSITIVE CASES IN FACILITY AT PRESENT: YES / NO

VISIT DATE: _____/_____/_____

FIRST PATIENT

GP'S NAME: _____ GP PRACTICE PHONE NUMBER: _____

PT SURNAME:_____ PT FIRST NAME: _____ D/O/B: _____

MEDICARE / REPAT CARD NO: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ REF : _____ GENDER: M / F

LEVEL/FLOOR: _____ SECTION:_____

KNOWN ALLERGIES: _____

COMPLAINT OF PT: _____

SECOND PATIENT

GP'S NAME: _____ GP PRACTICE PHONE NUMBER: _____

PT SURNAME:_____ PT FIRST NAME: _____ D/O/B: _____

MEDICARE / REPAT CARD NO: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ REF : _____ GENDER: M / F

LEVEL/FLOOR: _____ SECTION:_____

KNOWN ALLERGIES: _____

COMPLAINT OF PT: _____

THIRD PATIENT

GP'S NAME: _____ GP PRACTICE PHONE NUMBER: _____

PT SURNAME:_____ PT FIRST NAME: _____ D/O/B: _____

MEDICARE / REPAT CARD NO: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ REF : _____ GENDER: M / F

LEVEL/FLOOR: _____ SECTION:_____

KNOWN ALLERGIES: _____

COMPLAINT OF PT: _____

FOURTH PATIENT

GP'S NAME: _____ GP PRACTICE PHONE NUMBER: _____

PT SURNAME:_____ PT FIRST NAME: _____ D/O/B: _____

MEDICARE / REPAT CARD NO: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ REF : _____ GENDER: M / F

LEVEL/FLOOR: _____ SECTION:_____

KNOWN ALLERGIES: _____

COMPLAINT OF PT: _____