

For referral to the Medical Ambulatory Day Unit (MADU). Please complete all sections and fax to: 8395 9199

## Referring GP Details

Name:	Phone:	Fax:
Address:		

## Patient details

Family name:	Given name(s):
Date of birth:     /     /	Western Health UR Number:
Medicare no:	Pension no:
Note: if patient does not have a WH UR number, Medicare number & Pension number (if applicable) must be provided	
Address:	
Phone numbers. Home;	Mobile:
Language spoken at home:	Interpreter required   Yes <input type="checkbox"/> No <input type="checkbox"/>
NOK name:	NOK Phone:
Can patient sit in a chair for the transfusion? Yes <input type="checkbox"/> No <input type="checkbox"/>	If the patient suffers dementia, will a family member be in attendance?   Yes <input type="checkbox"/> No <input type="checkbox"/>

## Clinical information

Relevant past medical history & <b>cause of anaemia</b> :
Clinical indication for transfusion ( signs and symptoms):
Patient Haemoglobin:.....     Date of test:...../...../..... <b>**Please attach all recent pathology results</b>
Has an A4 Dorevitch Pathology blood product request form been printed from the WH GP Liaison website and the patient's WH UR number documented on the request form and this request form been given to the patient?   Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Note: 1.</b> Request form on the WH GP Liaison website <b>must be used</b> to ensure the patient's crossmatch sample is sent to the Western hospital blood bank not the main lab at Heidelberg. Crossmatch cannot be performed without UR number and sample. <b>Note: 2. Crossmatch <u>must be</u></b> done by Dorevitch Pathology - no other pathology service can be accepted.
Known Allergies:
Current Medications:

## MADU Nursing staff use

Admission date: ...../...../.....     Patient informed?   Yes <input type="checkbox"/> No <input type="checkbox"/> Date...../...../.....
Patient advised to attend Dorevitch Pathology for crossmatch on date: ...../...../.....