Referral & Consent Form

Please complete all fields, print, sign and forward to Melbourne Oncology & Home Infusion Services (MOHIS).
If required please complete necessary medication and prescription orders and forward along with the referral.
P: **1800 941 001** **F: 03 8692 8640** Email: **referrals@mohis.com.au**

MOHIS
Specialist Nursing Services

Patient details – *please click in the space provided to enter text*	
Date:	Telephone: Mobile:
Title (Dr, Mr, Mrs, Ms, Miss): First name:	Email address:
Surname:	Medicare number:
Date of birth: Gender:	Health Fund (if applicable): Membership No:
Address: State: Postcode:	Alternate contact name: Telephone: Mobile:
Language:	Concession card:

Consultant details	Hospital details
Consultant: Provider No.:	Hospital:
Telephone: Fax:	Hosp. URN:
Mobile:	Telephone:
Email address:	Clinical Nurse Consultant:
GP Name:	Telephone: Fax:
Telephone: Fax:	Mobile:
Mobile:	Email address:

Service required	
Diagnosis:	Proposed commencement date for MOHIS**:**
Home infusion service: Treatment details:	
Home injection service: Treatment details:	
Oral chemotherapy and patient support service: Treatment details:	
No. of cycles given in hospital: Visits (single or ongoing):	No. of cycles to be delivered by MOHIS:
Please give details of any previous adverse reactions / hypersensitivity:	

Venous access	**Bloods**
IV cannulation (yes/no):	Pre-treatment bloods required (yes/no):
CVAD (yes/no):	Pathology service provider:
Insertion date (if known):	Pathology requests given to patient (yes/no):

Doctor and Patient Consent	
All necessary prescriptions have been given to the patient & prescriptions scanned and emailed to MOHIS	
I confirm this referral for treatment at Home is to be provided as substitutional treatment for inpatient hospital care, and if the service were not delivered, the patient would be in hospital on each day the service was provided.	
Patient/parent/guardian: Name:	Referring Clinician:
Signature Date:	Signature Date:

Consent to claim from Private Health Insurer	
I confirm that I have no entitlement to compensation or damages in relation to this claim. I have not lodged a claim for compensation or damages. I confirm that any financial implications of the service charges have been explained to me prior to treatment. I authorise the service provider or any other authorities concerned with this facilitation, injury, disease or ailment, or the treatment or diagnosis, to supply all information to the private health fund for the purpose of providing private health insurance in accordance with the funds privacy policy. I authorise my health fund to pay benefits directly to the provider of this service.	
Patient/parent/guardian: Name:	Date:

This document contains confidential information. If you are not the intended recipient, please notify the sender immediately by phone, and destroy any copies.