Latrobe HEALTH SERVICES

Private Health Insurance Code of Conduct

Home Services

REFERRAL FORM

Adhere printed label or write patient details

REASON FOR REFERRAL

Membership No: _____

- ☐ Advanced Acute Surgery
- ☐ Maternity
- ☐ Palliative Care
- ☐ Name of Hospital _____
- ☐ Date of Discharge _____/_____/_____
- ☐ Date Service to Commence _____/_____/_____

Condition CMBS Number: _____(We understand this could alter, but it is necessary to determine the initial diagnosis)

I hereby certify that this patient is pregnant/awaiting or has undergone acute surgery/requires palliative care and would benefit from assistance with home services.

Signed: _____ Date: _____/_____/_____

Print Name: _____ Contact Phone: _____

Return Address: PO Box 41, Morwell, VICTORIA 3840 Telephone 1300 362 144 ABN 94 137 187 010