

# Ambulance Victoria referral

Purpose: referral out to services that have a partnership agreement with Ambulance Victoria.

## Consumer

Name: \_\_\_\_\_

Date of Birth: dd/mm/yyyy / /

Sex: \_\_\_\_\_

UR Number: \_\_\_\_\_

or affix label here

Referral date: dd/mm/yyyy / /

AV case number: \_\_\_\_\_

### Referral to:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

### Referral from:

Name: AMBULANCE VICTORIA 000 Referral Service

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Triage notes / summary of events leading to referral:

Reason for referral:

### Patient details:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of birth: dd/mm/yyyy / /

Gender: \_\_\_\_\_

### Call details:

Time of call: \_\_\_\_\_

Nursing home patient: \_\_\_\_\_

Timeframe for referral advised: \_\_\_\_\_

The patient has consented to this referral.

Please page 'referral service' on \_\_\_\_\_ on receipt of referral, or as per partnership agreement

Ambulance Victoria referral

Produced by the Victorian Department of Health, 2012

This information collected by:

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Name: \_\_\_\_\_

Position/Agency: \_\_\_\_\_

Sign: \_\_\_\_\_

Date: dd/mm/yyyy / /

Contact number: \_\_\_\_\_