

REFERRAL FORM



Care2 Home | HEN Support Program

Patient Name: _____

Patient Date of Birth: _____ Expected Discharge Date: _____

Patient Address: _____

State: _____ Postcode: _____

Patient Phone Number: _____ Mobile: _____

Name of Carer: _____ Carer Contact Number: _____

Referring Hospital: _____

Referrer's Name and Title: _____

Referrer's Phone Number: _____

Referrer's Fax: _____ Referrer's Email: _____

Name of Feed: _____

FEED DELIVERY TYPE:

☐ Kangaroo Joey Pump

Other: _____

☐ Kangaroo ePump

☐ Kangaroo Connect Pump

☐ Syringe (Bolus)

☐ Gravity

Giving Set product code: _____

FEEDING TUBE TYPE:

☐ NG tube Fr size _____ type _____ brand _____

☐ NJ tube Fr size _____ type _____ brand _____

☐ Initial Placement PEG Fr size _____ type _____ brand _____

☐ G tube Fr size _____ type _____ brand _____

☐ Skin Level Device Fr size _____ type _____ brand _____

☐ Other Fr size _____ type _____ brand _____

Date of Tube Insertion: _____

Feeding Regimen: _____

Flush Regimen: _____

Other Notes: _____

For more information please call 1300 824 663 or email us at info@regalhealth.com.au