



Facility: Sutherland Hospital –
Southcare

**REFERRAL
GERIATRIC FLYING SQUAD**

Date: _____ M/C or DVA: _____

Attached referral: ☐ YES ☐ NO GP consent: ☐ YES ☐ NO GP Name: _____

Facility: _____

Name of referrer : _____ Position: _____ Signature: _____

GERIATRIC FLYING SQUAD - REFERRAL

CHECKLIST Please ☒ and provide details if available

1	Are you able to contact GP?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	• Are they able/unable to attend?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	• Have they requested Geriatric Flying Squad involvement?	<input type="checkbox"/> YES <input type="checkbox"/> NO

2	What is your concern for this resident?	
	• How is this different to usual	

3	Have you attended to a set of current observations? (as far as possible).	
	<input type="checkbox"/> Temperature _____	
	<input type="checkbox"/> Pulse _____	
	<input type="checkbox"/> Blood Pressure _____	
	<input type="checkbox"/> Respiratory Rate _____	
	<input type="checkbox"/> Urinalysis _____	
	<input type="checkbox"/> Blood Sugar Level _____	
	<input type="checkbox"/> O2 sats _____	
	<input type="checkbox"/> Date bowels last opened _____	

4	Is family/person responsible aware of concerns?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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5	Is there an Advance Care Directive, Living Will or other NFR document which may preclude resident being transferred to hospital?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	Have documentation available.	

6	If hospital transfer is recommended, copies of the following should go with the resident.	
	<input type="checkbox"/> Resident details/ transfer form/contact for person responsible	
	<input type="checkbox"/> Advance Care Directive	
	<input type="checkbox"/> Medication Chart	
	<input type="checkbox"/> Letter stating why resident is being transferred	
	<input type="checkbox"/> Copies of current observations.	

FAX TO SOUTHCARE INTAKE FAX NUMBER: 9540 7869