

**APAC**  
*Acute/Post Acute Care*

Professional Health Care In Your Own Environment

**(Please give original to Patient to give to APAC)**

Dr <<Doctor:Name>>  
Provider No. <<Doctor:Provider Number>>  
<<Practice:Name>>  
<<Practice:Address>>  
Ph <<Practice:Phone>>  
Fax <<Practice:Fax>>

<<Miscellaneous:Date (short)>>

Dear APAC,

**Re:** <<Patient Demographics:Full Name>>  
**DOB:** <<Patient Demographics:DOB>>  
**Address:** <<Patient Demographics:Address>>

**Confirm patients address above is correct (Y/N)**

**Phone:**<<Patient Demographics:Phone (Home)>>  
**Mobile:**<<Patient Demographics:Phone (Mobile)>>  
**Medicare No:** <<Patient Demographics:Medicare Number>>

Thank you for seeing <<Patient Demographics:Full Name>> age <<Patient Demographics:Age>> for management of <\_<insert diagnosis for management here>> by APAC / GP Shared Care.

**Patient has verbally consented to management by APAC /GP Shared Care:** <<Pt has verbally consented to management by APAC>>

**Date service to commence:** <<Date APAC service to commence:>>

**Presenting Problem and Examination Summary:**  
<<Presenting Problem and Examination Summary:>>

**Past History:**  
<<Clinical Details:History List>>

**Allergies:**  
<<Clinical Details:Allergies>>

**Current Medications:**  
<<Clinical Details:Medication List>>

I am contactable on: Ph <<Doctor:Phone>> or e-mail me at <<Doctor:E-mail>>

Follow-up appointment has been made for: **Date:** <<Follow up appointment date:>>  
**Time:** <<Follow up appointment time: >>

Thank you  
Yours sincerely,

<<Doctor:Name>>

PLEASE KEEP MEDICATION AUTHORITY ON SEPARATE PAGE

**APAC MEDICATION AUTHORITY**

*(Please give original to Patient to give to APAC)*

**PATIENT'S NAME:** <<Patient Demographics:Full Name>>      **DOB:** <<Patient Demographics:DOB>>

**SEX:** <<Patient Demographics:Sex>>

**ADDRESS:** <<Patient Demographics:Full Address>>

**Weight (in kgs):** <<Patients weight in kg:>>

**Patients Previous weight recordings:**

<<Clinical Details:Measurements>>

**Allergies:** <<Clinical Details:Allergies>>

**Most Recent Pathology:**

<<Summary:Investigation Results (Selected)>>

**PLEASE PRINT ON THIS FORM:**

Medication	Route	DATE → TIME ↓							
Dose	Frequency								
GP Signature									
GP Name (Print) <<Doctor:Name>>	Date <<Miscellaneous:Date (short)>>								
Medication	Route	DATE → TIME ↓							
Dose	Frequency								
GP Signature									
GP Name (Print) <<Doctor:Name>>	Date <<Miscellaneous:Date (short)>>								

**Note:**

- Please ensure patient's renal function is reviewed and patient is weighed prior to ordering LMWH treatment
- Patients on IV antibiotics are reviewed on day 2 or 3
- Approved Abbreviations:      D = Daily                      BD = twice Daily                      Mane = In the morning

