

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

