Paediatric PAC Request for Funded Home Care Nurse Visits Form

Patient Details:

Surname: ____________________ **UR No:** ____________

Given Names: ____________________

DOB: ____________________ **Sex:** ____________

Admission Date: ____________________

Consultant: ____________________ **Ward:** ____________

USE LABEL IF AVAILABLE

Date of admission to ward:	**Date of discharge from ward:**

Indigenous status	☐ Aboriginal ☐ Torres Islander ☐ Aboriginal and Torres Islander
Reason/plan for visits	☐ Weight management ☐ Feeding management ☐ Jaundice monitoring ☐ Oxygen dependence ☐ Other:

Bendigo Health department patient referred into:

☐ Midwifery Home Care (MHC) Phone: 5454 7283 Fax: 5454 7274

☐ MAMTA Phone: 5454 7274 Fax: 5454 7274

☐ PAED PAC Homecare Phone: 5454 7807 Fax: 5454 7800

☐ Other (include name, address, phone, fax and contact):

PAED PAC required on completion of Midwifery Home Care? ☐ **Yes** ☐ **No**

Service Category	Start Date	End Date	No. of Units	Rate	Total Cost
1. Home Care Visits				89.30	

Please list dates of all visits here:

REQUEST FOR INTERNAL TRANSFER JOURNAL ENTRY

The following Journal is required for the month of:

Transfer *from* (expense)

DR:	Cost Centre:	**D0002**	Subjective:	**61902**	Amount:
	Department:	**PAC**	Authorisation:		

Transfer *to* (revenue)

DR:	Cost Centre:(*circle*)	C1352 / C1353 / M4014	Other:
	Subjective:	57810 / 38670	Amount:
	Department:(*circle*)	MHC / MAMTA / PAED PAC	Other:
	Authorisation:		

Please scan and send this completed form to PAC at PACeReferral@bendigohealth.org.au