Quro Medical
Innovation with care

PATIENT REFERRAL FORM

Kindly complete all requested fields in full.
Information is required to submit
pre-authorisation request from medical schemes

PATIENT INFORMATION (or STICKER)	
FULL NAME:	DATE:
ID NUMBER:	ICD10 CODE(S):
CELL NO.:	
MEDICAL AID:	
OPTION:	
MEDICAL AID NO.:	
CONTACT:	**NEXT OF KIN DETAILS**
PATIENT ADDRESS:	NAME:
	CONTACT:

SELECT QURO MEDICAL SERVICE OPTION

- ☐ Hospital-at-Home
- ☐ Remote Patient Monitoring & Clinical Oversight

Remote Patient Monitoring (RPM) service: The patient receives: Continuous remote vital signs monitoring • Daily virtual visits • Clinical team available 24/7 at our clinical command centre • Rapid response protocols • Short-term homeoxygen (as required).
Hospital at home (HAH) service: The patient receives: ALL of the above AND • in-person clinical home visits by a member of our healthcare team for 3 days • Medication administration • Access to pathology laboratory services • Allied health services, including physiotherapy (if required).

REFERRING DOCTOR VIRTUAL OVERSIGHT OPTION

Please choose relevant option:

☐ Opt in ☐ Opt out

Please note: Only doctors who opt-in are reimbursed for continuing to provide virtual clinical oversight for their patients
Virtual Clinical Oversight (Opt-in doctors only): Doctors are invited to provide virtual clinical oversight for their patients for the duration of their patient's admission to Quro Medical. As the treating doctor, you remain ultimately responsible for the patient's clinical management. We ask that you remain engaged in the care of your patient through the Quro Medical Insight platform (https://insight.quromedical.com/).

KEY REFERRAL INFORMATION

Indication for admission to Quro Medical Service:

Clinical Findings and Relevant Investigations (please attach copies of results):

Baseline Vitals:
HR: _____ RR: _____
Temp: _____ Sats: _____
BP: _____ BMI: _____

Care Plan (e.g., Day 2 - white cell count, daily chest physio):

Current Chronic Medication (include all medication and dosages):

PRESCRIPTION (ACUTE MEDICATION)

DRUG NAME	DOSE	ROUTE	FREQUENCY	DURATION

Please scan and email form to providers@quromedical.co.za or fax2email to 086 521 0691.

Dr Initial and Surname:

Practice Number:

Dr Signature:

General inquiries: +27 (0) 10 824-1150 Referral inquiries: 010 141 7715
WhatsApp: 078 362 5688 email: providers@quromedical.co.za
www.quromedical.co.za