RHC101670

Rehabilitation Unit Pre-Admission & Referral Form

Ramsay Health Care

Rehab Unit Name/Contact/Fax No/Email:
The Southport Private Hospital
Inpt Ph: (07) 5671 8006 / Daypt Ph: (07) 5671 8342
Fax: (07) 5671 8343
E: rehabilitationunitreferral.tsp@ramsayhealth.com.au

Surname: _____

Given Name: _____

Address: _____

DOB: _____ Sex: _____

(Affix Patient Identification label here, if available)

REFERRAL DETAILS

Referral to: (Optional)

☐ **INPATIENT REFERRAL** (assessed as requiring 24 hour nursing care)
☐ **DAY PROGRAM REFERRAL** (full day / half day)

Referring Dr:

Signature:

Ph: **Provider No:**

Referral Date:	Requested admission date:	Patient Ph:
Person for notification: Address:	Ph:	Relationship:
Usual GP:	Medicare No.:	Exp:
Patient Health Fund:	Health fund No.:	DVA No.:

☐ Workers Comp ☐ Third Party: **If yes:** Insurance Company: Claim number:

Case Manager: Phone:

Is the patient an existing NDIS participant? ☐ Yes ☐ No ☐ Application pending ☐ Considering

Pt Location: ☐ Home ☐ Hospital: Ward: Bed: Ward Phone:

Referrers Name: Position: Ward:

Infectious Status (e.g.MRSA/VRE/ESBL/CRE positive): **Results -** ☐ **Yes** ☐ **No** (please attach results)

PATIENT DETAILS

Diagnosis / HPI / Complications	
Relevant Past Medical History	
Allergies	
Clinical Risks (e.g. Delirium)	
Social Situation	
Proposed D/C destination	

CURRENT MOBILITY STATUS, LEVEL OF DEPENDENCE, ADLS

Mobility	☐ Indep ☐ S/V ☐ 1 Assist ☐ 2 Assist ☐ Immobile ☐ Walking Aid (Type):_____ Distance: _____m		
Transfers	☐ Indep ☐ S/V ☐ 1 Assist ☐ 2 Assist ☐ Standing Hoist ☐ Full Hoist		
Weight bearing	☐ FWB ☐ WBAT ☐ Partial WB (___%) ☐ TWB ☐ NWB Date of next WB status review:		
Cognition	☐ Alert ☐ Orientated ☐ Confused ☐ Wandering ☐ Non-compliant MOCA / MMSE score (if done):		
Falls Risk	☐ At Risk ☐ No risk	No. falls in last 6 months:	No. falls during current admission:
Continence	Bladder: ☐ Continent ☐ Incontinent ☐ IDC ☐ SPC	**Weight**	_____ kg
	Bowel: ☐ Continent ☐ Incontinent	**Toileting**	☐ Indep ☐ Supervision ☐ Assistance
Showering	☐ Indep ☐ Supervision ☐ Assistance	**Wounds**	☐ No ☐ Yes Specify:
Diet		**Communication**	
Fluids	☐ Thin ☐ Slightly Thick ☐ Mildly Thick ☐ Moderately Thick ☐ Extremely Thick ☐ Nil by Mouth		
Medication	☐ Independent ☐ Supervision ☐ Assist required ☐ PICC line ☐ IV AB's		
Previous functional status			

REHABILITATION PLAN & GOALS

Patient willingness and ability to comply with program? ☐ **YES** ☐ **NO**

Rehab Goals:

ASSESSMENT COMPLETED BY: Name: **Signature:** **Date:**

ACCEPTED BY VMO: Name: **Signature:** **Date:**

Please send a copy of: **1)** Recent progress and admission notes **2)** Medication charts **3)** Recent pathology results/scans and **4)** ECG + any other information you feel is relevant to the referral.

Reset Form

Email Completed Form

BINDING MARGIN - DO NOT WRITE

REHABILITATION UNIT PRE-ADMISSION & REFERRAL FORM RHC 45