Calvary

Adelaide Hospital

INPATIENT REHABILITATION REFERRAL FORM

Family Name _____

Given Names _____

Address _____

_____

Phone No. _____

Date of Birth | | | | | | | | | Age | |

Sex | | Room No. _____ OR USE LABEL

Phone: 08 8227 6736 Fax: 08 8227 6782 Email: SA-CAH-Admissions@calvarycare.org.au (EMAIL REFERRALS PREFERED)

REFERRAL SOURCE

Referral Authorised by or on behalf of Dr _____ Signed: _____

Referring Hospital: _____ Ward: _____ Doctor: _____

Date of admission: _____ Referral date: _____

Assessment date: _____ Expected transfer date: _____

PERSONAL INFORMATION

Next of Kin: Name _____

Contact Details: Phone (hm) _____ Mobile: _____

Health Fund: _____ Membership No. _____

Medicare No. _____ Insurance claim Nos. (if applicable): _____

General Practitioner details: _____ Phone: _____

MEDICAL INFORMATION

Diagnosis: _____ Operation date: _____

Current issues / Comments: _____

_____

Cognitive Status: ☐ Alert ☐ Orientated ☐ Co-operative ☐ Confused ☐ Dementia

Mobility: ☐ W/C ☐ Crutches ☐ Frame ☐ Stick/s ☐ Independent

ADL's: ☐ Independent ☐ Supervision ☐ Mod. Assist ☐ Min. Assist ☐ Full Assist

Continence: ☐ Continent ☐ Incontinent Urine ☐ SPC / IDC ☐ Incontinent Faeces ☐ Colostomy

Feeding: ☐ Self ☐ Assist ☐ NGT ☐ PEG

☐ Diet: _____

Skin Integrity: ☐ Intact ☐ Wound ☐ Pressure Areas ☐ Ulcers

☐ Dressing - Type/Frequency: _____

Patient Weight: _____ (kgs) Known infectious status : Yes ☐ No ☐ Please specify: _____

FOR OFFICE USE ONLY - Assessor's Comments: _____

_____

_____

_____

_____

Level of cover _____ Waiting period _____

Financial _____ Excess / Co-payments _____ Comments _____

Continuing the mission of the Sisters of the Little Company of Mary.