Calvary

John James Hospital

External Inpatient Rehabilitation Referral

Version 3, June 2023

Unit Record No .....

Surname.....

Given Names.....

D.O.B ..... Sex.....

TO BE COMPLETED BY, or on behalf of, referring Doctor at REFERRING HOSPITAL – Referring Doctor must sign below. All sections must be completed.

Dear Dr Speldewinde/Dr Boris Ivanov/Other: _____ (Circle preference if any)

Date of Referral _____

Please email referral to: **rehab-referrals@calvarycare.org.au**

- Further details or a preadmission assessment may be required
- If the patient meets our admission criteria you will be contacted with bed availability

Patient Name: _____ **Private Health Fund**:_____

Name of Doctor referring: _____ **Health fund policy number:**_____

Signature of Referring Doctor:_____ **Contact Number:** _____

Referring Hospital: _____ Ward: _____

Direct Ward Phone Number (in full) : _____

Diagnosis for Rehab Admission: _____

Date of Admission:_____ Date of Surgery:_____

Post Op Instructions:_____

AND / OR

Current Medical Status / diagnosis:

_____

_____

Patient medically ready for Transfer to Rehab: □ Yes □ No Desired T/F Date:_____

Medical Stability	**YES**	**NO**	**Details**
Was the patients MEWS score >3 in the past 48 hours?			
Does the patient have an altered MEWS criteria?			
Is the patient on oxygen?			
Does the patient have any outstanding pathology, imaging or interventions organised or to be arranged?			
Last Obs: Date ___/___/___ BP ____/____ HR___ T___ RR___ Pain score_____			

Medical History:_____

_____

_____

Allergies – type and reaction: _____

BINDING MARGIN DO NOT WRTIE

INPATIENT REHABILITATION REFERRAL

MR 1c

_____

Allied health, please complete rehabilitation goals:

1._____

2._____

3._____

Social History: **Is carer for someone:**	□ Lives Alone □ Yes □ No	□ Lives with: □ Partner/ Spouse □ Relative / other_____ □ Has Carer: □ No □ Yes: □ Carer living in □ Carer not living in	
Accommodation Type:	□ House □ Unit □ Stairs_____	□ Retirement Village_____ □ ILU _____ □ Low care nursing home (hostel)_____ □ Residential Aged Care Facility _____	
Premorbid ADL Status:	□ Independent □ Supervision □ Assistance: □ Set up □ Min □ Mod □ Full		
Premorbid Mobility:	□ Independent □ Stand by □ Assist x 1 □ Assist x 2 □ Sara Stedy □ Stand up lifter □ Full sling hoist □ Mobility Aid: _____		
Community Services:	□ ACAT □ Package level_____ □ Provider_____ □ Other: _____		
Current Cognition:	□ No impairment □ Confused □ Delirium □ Dementia: type: _____		
Current Mobility:	□ Independent □ Stand by □ Assist x 1 □ Assist x 2 □ Sara Stedy □ Stand up lifter □ Full sling hoist □ Mobility Aid: _____		
Weight Bearing Status:	□ WBAT / FWB	□ PWB %_____ □ R/V date__/__/__	□ TWB □ R/V date__/__/__	□ NWB how long _____ □ R/V date:__/__/__
Sit To Stand:	□ Independent □ Assist x 1 □ Assist x 2 □ Sara Stedy □ Stand up lifter □ Full sling hoist		
Bed Transfers:	□ Independent □ Assist x 1 □ Assist x 2 □ Sara Stedy □ Stand up lifter □ Full sling hoist		
Current ADL Status:	□ Independent □ Supervision □ Assist: □ Set up □ Min □ Mod □ Full		
Current Continence:	Bladder: □ Yes □ No □ IDC: date for change__/__/__ □ SPC: date for change__/__/__ Bowels: □ Yes □ No □ Colostomy		
For spinal surgery pt: Is the patient wearing a brace?	□ No □ Yes □ Type: _____ □ How many hours a day? _____ □ Off for showering etc? _____ □ Next review date & x-ray: ___/___/___ □ Post Op Protocols:		

Current Exercise tolerance: □ Number of physio / OT sessions a day currently participating in: _____

□ Distance able to walk in metres _____ □ Time in minutes able to participate: _____

Current Physio and OT input & plan: _____

_____

Social work input / discharge plan or issues:_____

_____

- Enduring Power of Attorney: □ No □ Yes Name: _____ Document available □ Yes □ No
- Advanced Care Directive: □ No □ Yes: Please attach to this referral

Height: _____ Weight: _____ Diet: _____ Allergies:_____

Dietician/Speech R/V: □ No □ Yes: Details_____

MRSA □ Yes □ No **VRE** □ Yes □ No **Site**: _____ Date detected ____/____/_____

Other Infections: □ Yes □ No Site & Pathogen: _____

Wound Dressing(s):_____

<u>Room Option:</u>

Patient is happy with: □ Shared room □ Single room □ Single room with shared ensuite

Assessor Comments:

Admitting rehab doctor:_____ Accepted □ Yes □ No (reason) _____
Assessment Conducted: □ Face to face □ Phone
Patient Agrees to transfer to CJJH and agrees to participate in therapy: □ Yes □ No
Patient informed of costs or co-payments: □ Yes □ No
Rehabilitation Goals have been discussed with patient: □ Yes □ No
Date:_____/_____/_____ Signature:_____ Name:_____ Designation:_____