Rehabilitation Hospital

INPATIENT REFERRAL FORM

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Unit Record Number

Family Name ______

Given Names ______

Address ______

Date of Birth ______ Age ______

Sex ______ Room No. ______

OR USE LABEL

REFERRAL SOURCE

Referring Hospital: ______ Ward: ______ Doctor: ______

Date of admission: ______ Referral date: ______

Assessment date: ______ Expected transfer date: ______

PERSONAL INFORMATION

Name: ______

Address: ______

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

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.

Amended August 2014

INPATIENT REFERRAL FORM MR5