

PATIENT ID LABEL

Ur No.

Surname:

Given Names:

D.O.B.

**REFERRAL FORM**

**REHABILITATION UNIT**

LAUNCESTON

##### Page 1 of 2 (PLEASE COMPLETE 2ND PAGE)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Referred to:  🞎 Dr K Kalpurath 🞎 Dr D Tryambake 🞎 1st available Physician **REFERRAL FORM REHABILITATION UNIT LAUNCESTON** | | | Date: | |
| Name of Referring Hospital: Ward: | | | | |
| Insurance: | 🞎 Private 🞎 DVA 🞎 MAIB 🞎 Other: | | | |
| Surgery: 🞎 Op Report (attached) Date: ……/……/ ……Procedure/s:    Surgeon:  Special Instructions: | Summary: | | | |
|  | Height: Weight: BMI: | | | |
| Referring Doctor: |  | | | |
| Contact: |  | | | |
| Doctor’s Signature: |  | Date: | |  |
|  | | | | |
| *For use by Rehabilitation Unit only* Accepted and Reviewed by Rehab Doctor – Date:  Assessed by Rehabilitation Team – Date: Signed:  Wait Listed for Rehabilitation – Date: Signed:  Patient Goals of Care identified at referral:    Ongoing Communication: | | | | |
| Please rehabilitation ward with referral queries on: 03 63353345 | | | | |
| Please scan and email form to [RehabReferrals@calvarycare.org.au](mailto:RehabReferrals@calvarycare.org.au) on completion | | | | |

**REFERRAL FORM**

PATIENT ID LABEL

Ur No.

Surname:

Given Names:

D.O.B.

**REHABILITATION UNIT**

LAUNCESTON

**Nursing Section**

##### Page 2 of 2

**REFERRAL FORM REHABILITATION UNIT LAUNCESTON – NURSING**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **History of current illness:** | | | | |
| **Pre-morbid mobility / level of function:** | | | | |
| **Current mobility / level of function:** | | | | |
| **Mental Status** | **Self-Care** | **Mobility** | **Weight Bearing** | **Attachments** |
| 🞎 Alert & orientated | 🞎 Independent | 🞎 Independent | 🞎 Non weight bearing | 🞎 Tracheostomy |
| 🞎 Confused | 🞎 Set-up | 🞎 Standby Assist. | 🞎 Touch weight bearing | 🞎 NG/PEG/PEJ Tube |
| 🞎 Wanderer | 🞎 Min. Assistance | 🞎 Min. Assistance | 🞎 Partial weight bearing | 🞎 Ostomy bags |
| 🞎 Aggressive | 🞎 Mod. Assistance | 🞎 Mod. Assistance | 🞎 Full weight bearing | 🞎 Other  ……………………... |
| 🞎 MME............Score | 🞎 Dependent | 🞎 Dependent | Review ..../.…./…. |
|  | | | | |
| **Aids** | 🞎 Commode  🞎 Over toilet frame | Transfer Aid:  Gait Aid: | | Detail: |
|  | | | | |
| **Communication:**  **Hearing / Vision:** | | | | |
| **Swallowing:**  **Food Texture/Fluid Consistency:**  **Diet:** | | | | |
| **Respiratory:**  **Dressing / Skin Integrity:** | | | | |
| **Bladder:** ……………………………………………………**Bowels:** | | | | |
| **MRSA 🞎 VRE 🞎 Other** | | | | |
| **Home Environment:**    **Community Supports:** | | | | |
| **Psychological Status:** | | | | |
| **Allied Health Staff Involved:**  Name Discipline Contact No. | | | | |
| **Completed by:** Name: Designation: Date: | | | | |