Ramsay Health Care

Rehabilitation Unit Pre-Admission & Referral Form

URN: ______________________

Surname: ______________________

Given Name: ______________________

DOB: ______________ Sex: ☐ M ☐ F

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Unit Name: Nambour Selangor Private Hospital | Fax No.: 07 5459 7462

REFERRAL DETAILS

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

Referring Dr: | Ph: | Provider No:

Referral for: ☐ Dr Georgius ☐ Dr Harrington ☐ Dr MacIntosh ☐ Dr Milburn ☐ Dr Tampiyappa

Referral Date: | Requested admission date: | Patient Ph:

3HUVRQ IRU QRWL¿FDWLRQ | 3K

Usual GP: | Medicare No.: | Exp:

Patient Health Fund: | Health fund No.: | DVA No.:

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

Is the patient an existing NDIS participant? ☐ Yes ☐ No
Is an application for NDIS eligibility being considered for this admission? ☐ Yes ☐ No ☐ Unsure

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	
Relevant Past Medical History	
Allergies	
Clinical Risks	
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	☐ Full ☐ Non ☐ Touch ☐ Partial Date of next Review of WB Status:
Cognition	☐ Alert ☐ 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/L0 ☐ Mildly Thick/L2 ☐ Moderately Thick/L3 ☐ Extremely Thick/L4 ☐ Nil by Mouth
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.

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