



RHC101670



Ramsay
Health Care

Rehabilitation Unit Pre-Admission & Referral Form

Rehab Unit Name/Contact/Fax No/Email:

Nambour Selangor Private Hospital
Phone: 0429 959 990
Fax: (07) 5459 7462
Email: rehabilitation.nph@ramsayhealth.com.au

Surname: _____

Given Name: _____

Address: _____

DOB: _____ Sex: _____

(Affix Patient Identification label here, if available)

REFERRAL DETAILS

Referral to: (Optional)

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

Referring Dr:

Signature:

Ph:

Provider No:

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

Person for notification: _____ Ph: _____ Relationship: _____
Address: _____

Usual GP: _____ Medicare No.: _____ Exp: _____

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

 Workers Comp Third Party: **If yes:** Insurance Company: _____ Claim number: _____

Case Manager: _____ Phone: _____

Is the patient an existing NDIS participant? Yes No Application pending ConsideringPt 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 / Complications _____

Relevant Past Medical History _____

Allergies _____

Clinical Risks (e.g. Delirium) _____

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** FWB WBAT Partial WB (____%) TWB NWB Date of next WB status review: _____**Cognition** Alert Orientated 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: _____**Continenence** Bladder: Continent Incontinent IDC SPC **Weight** _____ kgBowel: Continent Incontinent **Toileting** Indep Supervision Assistance**Showering** Indep Supervision Assistance **Wounds** No Yes Specify: _____**Diet** _____ **Communication** _____**Fluids** Thin Slightly Thick Mildly Thick Moderately Thick Extremely Thick Nil by Mouth**Medication** Independent Supervision Assist required PICC line IV AB's**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.**

BINDING MARGIN - DO NOT WRITE

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REHABILITATION UNIT PRE-ADMISSION & REFERRAL FORM

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