RHC300.29
Rehabilitation

Ramsay Health Care

Rehabilitation Unit Pre-Admission & Referral Form

URN: _____

Surname: _____

Given Name: _____

DOB: _____ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

Unit Name:	**Fax No.:**

REFERRAL DETAILS

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

Referring Dr:	Ph:	**Provider No:**
Referral Date:	Requested admission date:	Patient Ph:
Person for notification:	Ph:	Relationship:
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.

Reset Form

January 2022

Email Completed Form

REHABILITATION UNIT PRE-ADMISSION & REFERRAL FORM RHC 45

BINDING MARGIN - DO NOT WRITE