Ramsay Health Care

Rehabilitation Unit Pre-Admission & Referral Form

Rehab Unit Name/Contact/Fax No:

Surname: ______________________________

Given Name: ______________________________

Address: ______________________________

DOB: ____________________ Sex: ☐ M ☐ F

$I¿[3DWLHQW ,GHQWL¿FDWLRQ ODEHO KH

REFERRAL DETAILS

Referral to: (Optional)	Referring Dr:
☐ INPATIENT REFERRAL (assessed as requiring 24 hour nursing care)	(NIB only) Signature:
☐ DAY PROGRAM REFERRAL (full day / half day)	Ph: Provider No:

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:

Case Manager: Phone:

Is the patient an existing NDIS participant? ☐ Yes ☐ No ☐ Application pending ☐ Considering

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 / 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:
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 ☐ 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.

© Ramsay Health Care 2022