President Private HOSPITAL

TELEPHONE: 02 9521 7788
FAX (Inpatients): 02 9545 5284
FAX (Outpatients): 02 9542 2989
EMAIL: jcolburt@machealth.com.au

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME	
GIVEN NAMES	
D.O.B.	SEX
WARD	DOCTOR
UNIT NUMBER	

REHABILITATION REFERRAL

PROGRAM: ☐ INPATIENT ☐ DAY ONLY REHABILITATION ☐ OUTPATIENT

1. PATIENT DETAILS:

Patient's name: _____ DOB:_____/_____/_____ Age:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ W ☐ D ☐ Single room requested

Address: _____

Telephone:_____ Religion: _____ Country of birth: _____

Next of kin: _____ Relationship: _____ Telephone: _____

Medicare No.: _____ Expiry date:_____/_____/_____ Pension No.: _____

Private Health Fund:_____ Membership: _____

Is this injury a result of an accident? ☐ Yes ☐ No If Yes, is the claim accepted? ☐ Yes ☐ No

WC/CTP Insurance Co.:_____ Claim No.:_____

Case Manager: _____ Telephone: _____

2. REFERRAL DETAILS:

Expected date of admission to PPH:_____/_____/_____ Previous patient at PPH: ☐ Yes ☐ No Year: _____

Date of Referral:_____/_____/_____ Person referring:_____ Expected length of stay:_____

Referring from: a) Home _____ b) Hospital:_____

Referral hospital:_____ Ward: _____ Telephone: _____

Referring specialist: _____ Telephone: _____

Specialist Rooms address: _____

Date of MRSA Swabs: _____/_____/_____ Results:_____

GP: _____ Telephone:_____ Fax: _____

GP address:_____

Preferred Rehabilitation Specialist: _____

3. CLINICAL DETAILS:

Diagnosis/Operation: _____ Operation date:_____/_____/_____

Relevant history: _____

_____

Current medications: _____

_____

Allergies: _____

REHABILITATION REFERRAL

MR 6B

BINDING MARGIN – DO NOT WRITE

MSO114523/05/22 - Version 0

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3. CLINICAL DETAILS:
PHYSICAL AND MENTAL STATUS

Cognitive Status: ☐ Alert ☐ Orientated ☐ Co-operative ☐ Confused ☐ Dementia

Mobility: ☐ W/C ☐ FASF ☐ Rollator/PUF ☐ Stick/s
☐ Crutches ☐ Independent ☐ Minimum assist ☐ Moderate assist ☐ Supervision

ADL's: ☐ Independent ☐ Supervision ☐ Moderate assist ☐ Minimal assist
☐ Full assist ☐ Aids:_____

Weight Bearing Status: ☐ FWB ☐ WBAT ☐ PWB ☐ TWB ☐ NWB (for _____ wk)

Continence: ☐ Continent ☐ Incontinent Urine ☐ Incontinent Faeces
☐ SPC ☐ IDC

Feeding: ☐ Self ☐ Assist ☐ NGT ☐ PEG
☐ Diet:_____

Skin integrity: ☐ Intact ☐ Wound ☐ Pressure areas ☐ Ulcers
☐ Type of dressing:_____

Physical: ☐ Weight (kgs):_____ ☐ Hb:_____ ☐ Date last taken:_____/_____/_____

Specialist equipment: ☐ Yes ☐ No ☐ If Yes, equipment: _____

Social situation: ☐ Home ☐ Self Care Unit ☐ Hostel ☐ Nursing Home

Pre-Admission support: ☐ Self ☐ Live-in Spouse/Carer ☐ Commuity Service ☐ Non Live-in Care

Medical requirements: ☐ Oxygen

Rehabilitation Goals: 1: _____
2: _____
3: _____

PLEASE NOTE:
When a patient is transferred to **The President Private Hospital**, please ensure the following accompanies the patient:
☐ Appropriate discharge summaries (medical, nursing, allied health, list of medications, etc).
☐ Three days of medications supply.
☐ Details of follow-up appointment.
☐ Copies of report of relevant investigations (X-rays, pathology).

THE PRESIDENT PRIVATE HOSPITAL OFFICE USE ONLY:

Telephone Assessment conducted: ☐ Yes ☐ No Date:_____/_____/_____
Contact: _____ Telephone: _____
Face to Face Assessment conducted: ☐ Yes ☐ No Date:_____/_____/_____
Patient agrees to transfer to the **The President Private Hospital**, if accepted: ☐ Yes ☐ No
Patient aware of, and agrees to, participate in therapy: ☐ Yes ☐ No
Patient informed of costs/health fund excess or co-payment (if applicable) and other charges such as Allied Health/Transport to and from the hospital: ☐ Yes ☐ No
Additional information: _____

Assessor:_____ Signed: _____ Date:_____/_____/_____

REHABILITATION REFERRAL

MR 6B

BINDING MARGIN – DO NOT WRITE