HammondCare
Champion Life

Greenwich Hospital Rehabilitation Referral Form

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Family Name

Given Name

MRN | AMO | Date of Birth | ☐ Male ☐ Female

Address | Admission Date

WHEN REHABILITATION REFERRAL FORM IS COMPLETED, EMAIL OR FAX WITH COPY OF FRONT PAGE:

Email: greenwichrehab@hammond.com.au Fax: 9903 8332 Phone: 0417 450 941

Consent for faxing of patient information obtained ☐ Yes Date of Referral

Referral Hospital/Ward

Estimated date ready for transfer to Rehabilitation Facility

Main Contact Person

Referring Clinician | Signature | Designation

Preadmission Support

☐ By Self ☐ Live in Non-Spouse
☐ Spouse / Carer ☐ Community Services

Usual Place of Residence

☐ Home ☐ Hostel
☐ Self Care Unit ☐ Nursing Home

Medical Details Principal Diagnosis/Injury (Include date of last major intervention)

Pre-existing Conditions

Diet

☐ Normal
☐ Minced
☐ Pureed
☐ Other

Mobility Level

☐ Independent
☐ Assistance of 1
☐ Assistance of 2
☐ Other

Transfer

☐ Transfer Independently
☐ 1 Person Transfer
☐ Other

Weight Bearing Status

☐ Full
☐ Partial
☐ Touch
☐ Non-Weight Bearing

Using Walking Aid ☐ Yes ☐ No

If Yes ☐ Rollator Frame ☐ PUF ☐ W/S ☐ Crutches

Behavioural (Comment on any confusion to time, place, person etc.)

Infections

☐ MRSA
☐ VRE
☐ Other

Day Continence

☐ Yes
☐ No
☐ IDC/SPC/ Colostomy

Night Continence

☐ Yes
☐ No
☐ IDC/SPC/ Colostomy

Special Instructions for Rehab Provider (eg. Tracheostomy, Wound Care, Dialysis, Infection Control I Swab Results etc)

☐ None to Report

BINDING MARGIN – NO WRITING

REHABILITATION REFERRAL FORM