GREEWICH HOSPITAL

REHABILITATION INPATIENT REFERRAL FORM

FAMILY NAME		MRN
GIVEN NAME		☐ MALE ☐ FEMALE
DOB	M.O	
ADDRESS		
LOCATION/ WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Check all front-page details are correct including Medical Insurance and GP details. When completed, **fax or email with copy of front page**. Please phone Nurse Unit Manager on 0417 450 941
Email: greenwichrehab@hammond.com.au Fax: (Rehabilitation Ward) 02 9903 8332

Date of Referral: ______/______/______ Consent for Faxing of Patient Information Obtained: ☐

Estimated Date for Transfer to Rehabilitation Facility: ________/________/__________

Current Hospital & Ward: ____

NUM Name and Contact Number: ____

Reason for Rehabilitation: (i.e.goals): ____

____

____

____

Referring MO Name: ______________________________ Speciality ______________________________

Provider no: _________________________ Signature: _________________________ Date: ______/______/______

Has the patient been assessed by a Rehabilitation Specialist at current facility? ☐ Yes ☐ No

If yes, Name: ____________________________________ Date Assessed: _____/_____/______

Preadmission Support:	☐ By Self	☐ Spouse/Carer	☐ Live-in non spouse	☐ Community Services
Usual Place of Residence	☐ Home	☐ Self-Care Unit	☐ Hostel	☐ Nursing Home
2624/ACCR Approved:	☐ Yes ☐ No	If yes, what level of care ☐ High	☐ Low	☐ Respite

Medical Details

Principal Diagnosis/Injury: (include date of last major intervention): ____________________________

____

____

Pre-existing Conditions: ____

____

____

Cognition

MOCA: ______________________ Date: ______________________

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

____

Mobility Level	☐ Independent ☐ Assistance of 1 ☐ Assistance of 2 ☐ Other ____________________
Walking Aid	☐ Yes ☐ No If Yes: ☐ FASF ☐ PUF ☐ Rollator Frame ☐ W/S ☐ Crutches
Transfer	☐ Transfer independently ☐ 1 Person ☐ Other ______________________________
Weight Bearing Status:	☐ Full ☐ Partial ☐ Touch ☐ Non-weight Bearing

BINDING MARGIN NO WRITING

GREENWICH HOSPITAL REHABILITATION INPATIENT REFERRAL FORM

GREEWICH HOSPITAL

REHABILITATION INPATIENT REFERRAL FORM

FAMILY NAME		MRN
GIVEN NAME		☐ MALE ☐ FEMALE
DOB	M.O	
ADDRESS		
LOCATION/ WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Special Equipment Needs: (e.g. shower commode): ____

____

Drains/Lines etc: ____

Day Continence (Urine)	☐ Yes	☐ No	☐ IDC/SPC
Night time Continence (Urine)	☐ Yes	☐ No	☐ IDC/SPC
Day Continence (Faeces)	☐ Yes	☐ No	☐ Colostomy
Night time Continence (Faeces)	☐ Yes	☐ No	☐ Colostomy

Risk Assessment

Last Falls Risk assessment (e.g. Ontario) score and date: ______________________________________

Has the patient had any falls in hospital: ____

Last Waterlow assessment score and date: ____

Height: ____________________________ Weight: ____

Speech Pathology Alert: ☐ Yes ☐ No

Diet: ____

Fluids (Modified Fluids, Fluid Restriction): ____

Alergies: Food/Drugs: (nil known)

Isolation requirement: ☐ Yes ☐ No

If yes, details: ____

MRSA Status: swabs taken: ☐ Yes ☐ No If yes, date: _____/_____/ _____

Results: ☐ Nose ☐ Axillae ☐ Groin ☐ Wound

Discharge

Proposed discharge destination: ____

Carer/support on discharge: ____

Future appointments from discharging facility (date and time): ______________________________

Person Responsible:

Name: ______________________ Contact no 1: _________________ Contact no 2: _________________

Rehabilitation Use Only

Copy of Medication Chart Received Date: ____

Copy of Most Recent (last 48 hours) Observations Received Date: _______________________________

Copy of Most Recent Pathology Results Received: Date: ____________________________________

Patient accepted: ☐ Yes ☐ No If yes, date: If no, why ____________________________

Person Reviewing and Confirming Referral Information:

Name: __________________________ Signature: __________________________ Date: ____/____/ _____