



RHC101670

BINDING MARGIN - DO NOT WRITE

|                                                                                                                                                                                                                |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
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| <br><b>Ramsay</b><br>Health Care                                                                                                | <b>Rehabilitation Unit<br/>Pre-Admission &amp;<br/>Referral Form</b>                                                                                                                                                                   | Surname: _____                                                                                    |                                                                                                         |
| Rehab Unit Name/Contact/Fax No/Email:<br>Beleura Private Hospital<br>Assessor Ph: 0477 171 754 or 0477 171 232<br>Inpt Email: Rehab.BEL@ramsayhealth.com.au<br>Daypt Email: Outpatient.BEL@ramsayhealth.com.au |                                                                                                                                                                                                                                        | Given Name: _____                                                                                 |                                                                                                         |
|                                                                                                                                                                                                                |                                                                                                                                                                                                                                        | Address: _____                                                                                    |                                                                                                         |
|                                                                                                                                                                                                                |                                                                                                                                                                                                                                        | DOB: _____                                                                                        | Sex: _____                                                                                              |
| (Affix Patient Identification label here, if available)                                                                                                                                                        |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| <b>REFERRAL DETAILS</b>                                                                                                                                                                                        |                                                                                                                                                                                                                                        | <b>Referring Dr:</b>                                                                              |                                                                                                         |
| Referral to: (Optional)                                                                                                                                                                                        |                                                                                                                                                                                                                                        | <b>Signature:</b>                                                                                 |                                                                                                         |
| <input type="checkbox"/> <b>INPATIENT REFERRAL</b><br>(assessed as requiring 24 hour nursing care)                                                                                                             |                                                                                                                                                                                                                                        | <b>Ph:</b>                                                                                        |                                                                                                         |
| <input type="checkbox"/> <b>DAY PROGRAM REFERRAL</b> (full day / half day)                                                                                                                                     |                                                                                                                                                                                                                                        | <b>Provider No:</b>                                                                               |                                                                                                         |
| Referral Date:                                                                                                                                                                                                 | Requested admission date:                                                                                                                                                                                                              | Patient Ph:                                                                                       |                                                                                                         |
| Person for notification:<br>Address:                                                                                                                                                                           | Ph:                                                                                                                                                                                                                                    | Relationship:                                                                                     |                                                                                                         |
| Usual GP:                                                                                                                                                                                                      | Medicare No.:                                                                                                                                                                                                                          | Exp:                                                                                              |                                                                                                         |
| Patient Health Fund:                                                                                                                                                                                           | Health fund No.:                                                                                                                                                                                                                       | DVA No.:                                                                                          |                                                                                                         |
| <input type="checkbox"/> Workers Comp <input type="checkbox"/> Third Party: <b>If yes:</b> Insurance Company:                                                                                                  |                                                                                                                                                                                                                                        | Claim number:                                                                                     |                                                                                                         |
| Case Manager:                                                                                                                                                                                                  |                                                                                                                                                                                                                                        | Phone:                                                                                            |                                                                                                         |
| Is the patient an existing NDIS participant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Application pending <input type="checkbox"/> Considering                        |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| Pt Location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital:                                                                                                                                  |                                                                                                                                                                                                                                        | Ward:                                                                                             | Bed: Ward Phone:                                                                                        |
| Referrers Name:                                                                                                                                                                                                |                                                                                                                                                                                                                                        | Position:                                                                                         | Ward:                                                                                                   |
| <b>Infectious Status (e.g.MRSA/VRE/ESBL/CRE positive):</b>                                                                                                                                                     |                                                                                                                                                                                                                                        | <b>Results -</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (please attach results) |                                                                                                         |
| <b>PATIENT DETAILS</b>                                                                                                                                                                                         |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| Diagnosis / HPI / Complications                                                                                                                                                                                |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| Relevant Past Medical History                                                                                                                                                                                  |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| Allergies                                                                                                                                                                                                      |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| Clinical Risks (e.g. Delirium)                                                                                                                                                                                 |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| Social Situation                                                                                                                                                                                               |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| Proposed D/C destination                                                                                                                                                                                       |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| <b>CURRENT MOBILITY STATUS, LEVEL OF DEPENDENCE, ADLS</b>                                                                                                                                                      |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| <b>Mobility</b>                                                                                                                                                                                                | <input type="checkbox"/> Indep <input type="checkbox"/> S/V <input type="checkbox"/> 1 Assist <input type="checkbox"/> 2 Assist <input type="checkbox"/> Immobile <input type="checkbox"/> Walking Aid (Type): _____ Distance: _____ m |                                                                                                   |                                                                                                         |
| <b>Transfers</b>                                                                                                                                                                                               | <input type="checkbox"/> Indep <input type="checkbox"/> S/V <input type="checkbox"/> 1 Assist <input type="checkbox"/> 2 Assist <input type="checkbox"/> Standing Hoist <input type="checkbox"/> Full Hoist                            |                                                                                                   |                                                                                                         |
| <b>Weight bearing</b>                                                                                                                                                                                          | <input type="checkbox"/> FWB <input type="checkbox"/> WBAT <input type="checkbox"/> Partial WB (____ %) <input type="checkbox"/> TWB <input type="checkbox"/> NWB Date of next WB status review:                                       |                                                                                                   |                                                                                                         |
| <b>Cognition</b>                                                                                                                                                                                               | <input type="checkbox"/> Alert <input type="checkbox"/> Orientated <input type="checkbox"/> Confused <input type="checkbox"/> Wandering <input type="checkbox"/> Non-compliant MOCA / MMSE score (if done):                            |                                                                                                   |                                                                                                         |
| <b>Falls Risk</b>                                                                                                                                                                                              | <input type="checkbox"/> At Risk <input type="checkbox"/> No risk                                                                                                                                                                      | No. falls in last 6 months:                                                                       | No. falls during current admission:                                                                     |
| <b>Continence</b>                                                                                                                                                                                              | Bladder: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> IDC <input type="checkbox"/> SPC                                                                                             | <b>Weight</b>                                                                                     | _____ kg                                                                                                |
|                                                                                                                                                                                                                | Bowel: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent                                                                                                                                                         | <b>Toileting</b>                                                                                  | <input type="checkbox"/> Indep <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance |
| <b>Showering</b>                                                                                                                                                                                               | <input type="checkbox"/> Indep <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance                                                                                                                                | <b>Wounds</b>                                                                                     | <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:                                       |
| <b>Diet</b>                                                                                                                                                                                                    | <b>Communication</b>                                                                                                                                                                                                                   |                                                                                                   |                                                                                                         |
| <b>Fluids</b>                                                                                                                                                                                                  | <input type="checkbox"/> Thin <input type="checkbox"/> Slightly Thick <input type="checkbox"/> Mildly Thick <input type="checkbox"/> Moderately Thick <input type="checkbox"/> Extremely Thick <input type="checkbox"/> Nil by Mouth   |                                                                                                   |                                                                                                         |
| <b>Medication</b>                                                                                                                                                                                              | <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist required <input type="checkbox"/> PICC line <input type="checkbox"/> IV AB's                                                 |                                                                                                   |                                                                                                         |
| <b>Previous functional status</b>                                                                                                                                                                              |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| <b>REHABILITATION PLAN &amp; GOALS</b>                                                                                                                                                                         |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| Patient willingness and ability to comply with program? <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                               |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| <b>Rehab Goals:</b>                                                                                                                                                                                            |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |
| <b>ASSESSMENT COMPLETED BY: Name:</b>                                                                                                                                                                          |                                                                                                                                                                                                                                        | <b>Signature:</b>                                                                                 | <b>Date:</b>                                                                                            |
| <b>ACCEPTED BY VMO: Name:</b>                                                                                                                                                                                  |                                                                                                                                                                                                                                        | <b>Signature:</b>                                                                                 | <b>Date:</b>                                                                                            |
| 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.                  |                                                                                                                                                                                                                                        |                                                                                                   |                                                                                                         |