Beleura Private Hospital
Part of Ramsay Health Care

Rehabilitation Assessment Service Referral Form

URN: ______
Surname: ______
Given Name: ______
DOB: ______ Sex: ☐ M ☐ F
(Affix Patient Identification label here, if available)

Acute admission doctor: ______ **Provider No.:** ______
Signature: ______

REFERRAL DETAILS

☐ **INPATIENT – Rehab.BEL@ramsayhealth.com.au** ☐ **Outpatient.BEL@ramsayhealth.com.au**

Referrer Name/Designation:

Does patient require 24hr nursing care? ☐ Yes ☐ No

Referral Date: | Date ready for admission:

Patient Location: Ward: Phone:

Private Health Fund/Number:

☐ Workers Comp ☐ TAC Claim number:

PATIENT DETAILS

Diagnosis / Date of admission	
Relevant Past Medical History	
Allergies	
Social Situation / Discharge destination	

CURRENT MOBILITY STATUS, LEVEL OF DEPENDENCE, ADLS

Mobility	☐ Assist ☐ S/V ☐ Indep. ☐ Walking Aid (Type):______ Distance: ______m
Transfers	☐ Standing Hoist ☐ Assist ☐ S/V ☐ Indep.
Weight bearing	☐ Full ☐ Non ☐ Touch ☐ Partial Date of next Review of WB Status:
Cognition	Impairment: ☐ Yes ☐ No Comment:
Falls Risk	☐ Yes ☐ No | No. falls in last 6 months:
Continence	Bladder: ☐ Yes ☐ No ☐ IDC ☐ SPC
	Bowel: ☐ Yes ☐ No
Wound	☐ No ☐ Yes Specify:
Diet / Fluids	

REHABILITATION PLAN & GOALS

Patient willingness and ability to comply with program? ☐ **YES** ☐ **NO**

☐ **Orthopaedic**	☐ **Spinal**	☐ **Pulmonary**	**Rehab Goals:**
☐ **Recon**	☐ **Pain**	☐ **Musculoskeletal**	
☐ **Cardiac**	☐ **Neuro**	☐ **Oncology**	

ASSESSMENT BY RAS: 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.

BINDING MARGIN - DO NOT WRITE

REHABILITATION ASSESSMENT SERVICES REFERRAL FORM MR 420