

Referral / Pre Admission Assessment Form

Surname: _____
Given Names: _____
Date of Birth: _____

TO BE COMPLETED BY THE REFERRING HOSPITAL
Further details may be required on preadmission assessment. Bed Manager will assess suitability of proposed admission. If patient meets our admission criteria you will be contacted regarding bed availability

PLEASE FAX TO ADMISSIONS CLERK 02 9847 5096

REFERRAL DATE: _____ REQUESTED ADMISSION DATE: _____

SECTION 1 PATIENT DETAILS

Address			
Phone (Home)	Mobile		
Person for notification	Relationship		
Address			
Phone (home)	Phone (work)	Mobile	

SECTION 2 INSURANCE DETAILS

Health Fund Name	Fund Member number	Patient admit as DVA
Medicare number	Id: Exp:	DVA /pension number <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient claiming Workers Comp <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient claiming Third Party <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of insurance company	Claim number	
Contact person	Phone / contact number	
Liability accepted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Fax Number	

SECTION 3 CLINICAL DETAILS

Reason for rehabilitation / admission			
Past Medical History			
Referring Doctor	Patient currently in hospital <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, which hospital	Date of admission at that hospital		
Contact person	Ward	phone number	
Recent ACAT Assessment <input type="checkbox"/> Yes <input type="checkbox"/> No	Details		
Social History	<input type="checkbox"/> lives alone <input type="checkbox"/> lives with relative <input type="checkbox"/> lives with spouse/partner <input type="checkbox"/> lives with carer		
Type of accommodation	<input type="checkbox"/> home/unit <input type="checkbox"/> retirement village <input type="checkbox"/> low level care <input type="checkbox"/> high level care		
Premorbid ADL status	<input type="checkbox"/> independent <input type="checkbox"/> assist Mobility <input type="checkbox"/> Independent <input type="checkbox"/> with aids		
Community Services	<input type="checkbox"/> SHN <input type="checkbox"/> MOW <input type="checkbox"/> Home Care <input type="checkbox"/> other:		
Current Mental Status	<input type="checkbox"/> alert <input type="checkbox"/> orientated <input type="checkbox"/> confused <input type="checkbox"/> known wanderer		
Current Mobility Status	<input type="checkbox"/> independent <input type="checkbox"/> supervision <input type="checkbox"/> assist <input type="checkbox"/> with aids:		
Current Transfers	<input type="checkbox"/> independent <input type="checkbox"/> assist <input type="checkbox"/> x1 person <input type="checkbox"/> x2 people <input type="checkbox"/> lifter		
Current Self Care Status	<input type="checkbox"/> independent <input type="checkbox"/> supervision <input type="checkbox"/> assist		
Current Continence Status	Bladder <input type="checkbox"/> continent <input type="checkbox"/> incontinent <input type="checkbox"/> IDC		
	Bowel <input type="checkbox"/> continent <input type="checkbox"/> incontinent <input type="checkbox"/> colostomy		
Weight Bearing Status	<input type="checkbox"/> FBW <input type="checkbox"/> WBAT <input type="checkbox"/> PWB /TWB <input type="checkbox"/> NWB		
Wounds			<input type="checkbox"/> MRSA
Swallowing Intact <input type="checkbox"/> Yes <input type="checkbox"/> No	Diet <input type="checkbox"/> normal <input type="checkbox"/> special <input type="checkbox"/> tube fed		

MT WILGA OFFICE USE ONLY URN: _____ ADMIN No: _____

Health Fund Eligibility Yes No By Fax By email By phone Further Info/Assessment Required Yes No

Comments: _____
Confirmed Admission Date: _____ Specialist: _____ Ward/Bed: _____
Program Type: _____