Mt Wilga Private Hospital
Part of Ramsay Health Care

MEDICAL ADMISSION REFERRAL FORM

PLEASE FAX TO ADMISSIONS
02 9847 5096

EMAIL TO
Referral.mwp@ramsayhealth.com.au

Surname: _____

Given Name: _____

Date of Birth: _____

Please send a copy of 1) Recent progress and admission notes 2) Medication Chart 3) Recent pathology results/s 4) ECG + any other information you feel is relevant to the referral

Referral Date: **Requested Admission Date:**

Referral for: Dr **Referring Dr:**

Assessment Completed By: Name: Signature:

SECTION 1 PATIENT, NOTIFICATION, INSURANCE and REFERRER DETAILS

Patient Address:

Patient Phone (Home): Patient Mobile:

Person for notification: Relationship:

Address:

Phone (home): Phone (work): Mobile:

Health Fund Name: Fund Member No. Pension No.

Medicare No. Id: Exp: DVA No.

❒ Workers Comp ❒ Third Party *If yes,* Insurance Company: Claim No.

Contact Person: Phone/Contact Number Fax Number

Usual GP: NDIS Participant: ❒ No ❒ Yes

Patient currently in hospital: ❒ No ❒ Yes If yes, which hospital: Date of admission at that hospital:

Contact person: Ward / Bed No. Phone Number:

SECTION 2 CLINICAL HISTORY and CURRENT STATUS ASSESSMENT

Clinical diagnosis		**Advanced Care Directive**	❒ No ❒ Yes
Relevant Medical History			
Current Medical Treatment	Is patient receiving ongoing treatment for: ❒ renal dialysis ❒ radiotherapy ❒ chemotherapy ❒ IV/PICC ❒ Requires O_2 / Litres _____ Other *specify*:		
Allergies		**Infectious Status (e.g. MRSA/VRE/ESBL)**	Results: ❒ No ❒ Yes (please attach results)
Clinical Risks	Falls Risk: ❒ High ❒ Medium ❒ Low No. Falls in last 6 months: No. falls during current admission: Pressure Injury Risk: ❒ High ❒ Medium ❒ Low Pressure injury present: ❒ No ❒ Yes If yes, site:		
Social History / Situation	❒ lives alone ❒ lives with relative ❒ lives with spouse/partner ❒ lives with carer	**Proposed D/C Destination**	
Current accommodation	❒ home/unit ❒ number of stairs _____ ❒ retirement village/ILU ❒ residential care *circle:* low / high level care		
Previous ADL status	❒ independent ❒ assist	**Previous Mobility**	❒ independent ❒ assist ❒ with aids *specify*:
Previous Community Services	❒ SHNs ❒ MoW ❒ Home Care ❒ other *specify*:	**Current ACAT Assessment**	❒ No ❒ Yes
Wounds	❒ No ❒ Yes If yes, Dressings regime:	**Weight**	kg
Current Cognition Status	❒ alert ❒ orientated ❒ confused ❒ known wanderer MOCA / MMSE score *(if done):*		
Current Mobility Status	❒ independent ❒ supervision ❑ assist x1 person ❑ assist x2 person ❒ with aids *specify*:		Distance: _____m
Current Transfers	❒ independent ❒ supervision ❑ assist x1 person ❑ assist x2 person ❒ standing hoist ❑ lifting hoist		
Current Self Care Status	❒ independent ❒ supervision / prompting ❒ assist		
Current Continence Status	**Bladder:** ❒ continent ❒ incontinent ❒ IDC ❒ SPC	**Bowel:** ❒ continent ❒ incontinent ❒ colostomy	
Weight Bearing Status	❒ FWB ❒ WBAT ❒ PWB ❒ TWB ❒ NWB Date for next Review of WB Status : _____		
Swallowing Intact ❒ No ❒ Yes	**Fluids** ❒ normal ❒ mildly thick ❒ moderately thick ❒ fully thick ❒ nil by mouth	**Diet**	❒ normal ❒ special ❒ tube fed

SECTION 3 MEDICAL CARE GOALS

SECTION 4 MT WILGA OFFICE USE ONLY

URN:		ADMIN No:	
Health Fund Eligibility ❒ No ❒ Yes	❒ By Fax ❒ By email ❒ By phone	Further Info/Assessment Required	❒ No ❒ Yes
Comments:			
Confirmed Admission Date	Specialist	Ward/Bed	
Program Type			
Accepted by VMO:	Name: Signature:	Date:	