RHC300.29

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Rehabilitation

Ramsay
Health Care

Rehabilitation Unit Pre-Admission & Referral Form

Rehab Unit Name/Contact/Fax No:

Mt Wilga Private Hospital
Please send referrals to:

Referral.MWP@ramsayhealth.com.au

Surname: ______________________

Given Name: ______________________

Address: ______________________

DOB: ______________ Sex: ☐ M ☐ F

(Affix Patient Identification label here, if available)

REFERRAL DETAILS

Referral to: (Optional)

☐ **INPATIENT REFERRAL** (assessed as requiring 24 hour nursing care)

☐ **DAY PROGRAM REFERRAL** (full day / half day)

Referring Dr:

Signature:

Ph: **Provider No:**

Referral Date: / /	Requested admission date: / /	Patient Ph:

Person for notification: Ph: Relationship:

Usual GP:	Medicare No.: Exp:	
Patient Health Fund:	Health fund No.:	DVA No.:

☐ Workers Comp ☐ Third Party: **If yes:** Insurance Company: Claim number:

Case Manager: Phone:

Is the patient an existing NDIS participant? ☐ Yes ☐ No ☐ Application pending ☐ Considering

Pt Location: ☐ Home ☐ Hospital: Ward: Bed: Ward Phone:

Referrers Name: Position: Ward:

Infectious Status (e.g.MRSA/VRE/ESBL/CRE positive): **Results -** ☐ **Yes** ☐ **No** (please attach results)

PATIENT DETAILS

Field	
Diagnosis / HPI / Complications	
Relevant Past Medical History	
Allergies	
Clinical Risks (e.g. Delirium)	
Social Situation	
Proposed d/c destination	

CURRENT MOBILITY STATUS, LEVEL OF DEPENDENCE, ADLS

Mobility	☐ Indep ☐ s/v ☐ 1 Assist ☐ 2 Assist ☐ Immobile ☐ Walking Aid (Type):________ Distance: _____m
Transfers	☐ Indep ☐ s/v ☐ 1 Assist ☐ 2 Assist ☐ Standing Hoist ☐ Full Hoist
Weight bearing	☐ FWB ☐ WBAT ☐ Partial WB (____%) ☐ TWB ☐ NWB Date of next WB status review: / /
Cognition	☐ Alert ☐ Orientated ☐ Confused ☐ Wandering ☐ Non-compliant MOCA / MMSE score (if done):
Falls Risk	☐ At Risk ☐ No risk | No. falls in last 6 months: | No. falls during current admission:
Continence	Bladder: ☐ Continent ☐ Incontinent ☐ IDC ☐ SPC | **Weight** ____________ kg Bowel: ☐ Continent ☐ Incontinent | **Toileting** ☐ Indep ☐ Supervision ☐ Assistance
Showering	☐ Indep ☐ Supervision ☐ Assistance | **Wounds** ☐ No ☐ Yes Specify:
Diet	| **Communication**
Fluids	☐ Thin ☐ Slightly Thick ☐ Mildly Thick ☐ Moderately Thick ☐ Extremely Thick ☐ Nil by Mouth
Medication	☐ Independent ☐ Supervision ☐ Assist required ☐ PICC line ☐ IV AB's
Previous functional status	

REHABILITATION PLAN & GOALS

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

Rehab Goals:

ASSESSMENT COMPLETED BY: 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 UNIT PRE-ADMISSION & REFERRAL FORM

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