



RHC101670



Ramsay Health Care

Rehabilitation Unit Pre-Admission & Referral Form

Rehab Unit Name/Contact/Fax No/Email: Mt Wilga Rehabilitation Hospital Phone: (02) 9847 5000 Fax: (02) 9847 5096 Email: Referral.MWP@ramsayhealth.com.au

Surname: Given Name: Address: DOB: Sex: (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: Address: 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

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 Transfers Weight bearing Cognition Falls Risk Continenence Showering Diet Fluids Medication

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

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REHABILITATION UNIT PRE-ADMISSION & REFERRAL FORM RHC 45