	RHC300.29
	Rehabilitation



Health Care

Rehabilitation Unit Pre-Admission & Referral Form

UR:	
DOB:	Sex:
	(Affix Patient Identification label here, if available)

							mineation tabel	nere, n ur	ullubicj	
REFERRAL DET	AILS									
	EFERRAL		Y PROG	RAM REFER	RAL (fu	ull day /	half day)			
Referral for: Dr										
Referring Dr:			Ph:			Provider No:				
Referral Date:	/ /	Requested adm	ission da	te: / /		Patient Ph:				
Person for notific	ation:			Ph:		Relationship:				
Usual GP:			Medicar	e No.:		Exp:				
Patient Health Fu	ind:		Health f	und No.:		DVA No		0.:		
U Workers Com	p	arty: If yes: Insura	ance Con	npany:		Claim number:				
Is the patient an existing NDIS participant? Yes No Is an application for NDIS eligibility being considered for this admission? Yes No Unsure										
Pt Location:	Pt Location: Home Hospital: Ward:		Ward:	B	ed:	Ward Phor	ne:			
Referrers Name:	ers Name: Position: Phone:									
Infectious Status (e.g.MRSA/VRE/ESBL/CRE positive): Results - Yes No (please attach results)										
PATIENT DETAIL	S									
Diagnosis / HPI										
Relevant Past Me	edical History									
Allergies										
Clinical Risks										
Social Situation										
Proposed d/c des	stination									
CURRENT MOB	ILITY STATUS	, LEVEL OF DEP	ENDENC	E, ADLS						
Mobility	🗆 Indep 🗆	s/v 🛛 1 Assist	2 As	sist 🗌 Immol	bile 🗌	Walkin	g Aid (Type):	[Distance:	m
Transfers	🗆 Indep 🗆	s/v 🛛 1 Assist	2 As	sist 🗌 Stanc	ding Ho	ist 🗌 F	Full Hoist			
Weight bearing	ng 🛛 Full 🗋 Non 🗋 Touch 🗋 Partial Date of next Review of WB Status: / /									
Cognition	Alert 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 🛛 I	ncontiner	nt 🗌 IDC	□s	PC V	Veight		kg	
Continence	Bowel:	Continent 🗌 I	ncontine	nt Toil	eting	🗌 Inde	ep 🗌 Superv	ision 🗌	Assistance	
Showering	🗆 Indep 🗆	Supervision 🗌 As	sistance	Wounds		🗆 No	🗌 Yes Sp	ecify:		
Diet				Communica	ation					
Fluids	🗆 Normal	Mildly Thick /I	_150 🗌	Moderately	Thick /I	L400 [☐ Fully Thick	/L900	🗌 Nil by Mo	outh
Previous functiona	al status									

REHABILITATION PLAN & GOALS

Patient willingness and ability to comply with program? () YES

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 4) ECG + any other information you feel is relevant to the referral.	2) Medication charts	3) Recent pathology results/scans and

REHABILITATION UNIT PRE-ADMISSION & REFERRAL FORM

RHC001-AH

() NO