

Attention Dr. \_\_\_\_\_ or Admitting Doctor \_\_\_\_\_

### Patient details

Patient name \_\_\_\_\_ Title  Ms  Mrs  Mr  Other

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex  Male  Female  Intersex  Other  Not stated

Marital status  M  S  W  D

Indigenous status  Aboriginal  Torres Strait Islander  Both  Neither  Not stated

Address \_\_\_\_\_

Phone \_\_\_\_\_ Religion \_\_\_\_\_ Country of birth \_\_\_\_\_

Person for notification \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Mobile \_\_\_\_\_

GP name \_\_\_\_\_ GP phone \_\_\_\_\_

### Referral details

Referral date \_\_\_\_/\_\_\_\_/\_\_\_\_ Referring from  Home  Hospital \_\_\_\_\_ Ward \_\_\_\_\_

Original admission date \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone \_\_\_\_\_

Referring specialist \_\_\_\_\_ Provider no. \_\_\_\_\_

Signature \_\_\_\_\_ Date of referral \_\_\_\_/\_\_\_\_/\_\_\_\_

Expected date of admission to rehab \_\_\_\_/\_\_\_\_/\_\_\_\_ Previous patient  Yes  No

### Fund details

Medicare no. \_\_\_\_\_ Expiry date \_\_\_\_/\_\_\_\_/\_\_\_\_ Pension no. \_\_\_\_\_

Health fund \_\_\_\_\_ Membership no. \_\_\_\_\_

Is this injury the result of an insurable accident?  Yes  No

WC/CTP Insurance Company \_\_\_\_\_ Claim no. \_\_\_\_\_

Case manager \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

### Clinical details

Diagnosis/Operation \_\_\_\_\_ Op date \_\_\_\_/\_\_\_\_/\_\_\_\_

Relevant medical history \_\_\_\_\_

Current medications \_\_\_\_\_

Allergies \_\_\_\_\_  Nil known

Medical  O2 Gastro symptoms  Yes  No Flu symptoms  Yes  No

Multi resistant organisms  Nil  VRE  MRSA  ESBL Site \_\_\_\_\_

Cognitive status  Alert  Orientated  Cooperative  Dementia  
 Delirium  Night confusion  Confused  Impulsive behaviour

Mobility/transfers  Independent  Assist \_\_\_\_\_ person(s) min/mod/max  Hoist Aid \_\_\_\_\_

Weight bearing status  FWB/WBAT  PWB  TWB  NWB (for \_\_\_\_\_ more weeks)

ADL's  Independent  Supervision  Min assist  Mod assist  Full assist

Continence  Continent  Incontinent bowels  Incontinent bladder  
 IDC  SPC  Colostomy/Ileostomy

Nutrition  Diabetic  PEG Diet \_\_\_\_\_ Supplements \_\_\_\_\_

Fluids  Thin  Mildly thick  Mod thick  Fully thick

Skin integrity Pressure area/Grade \_\_\_\_\_ Location \_\_\_\_\_ Dressing \_\_\_\_\_  
 Wound  Yes  No Location \_\_\_\_\_ Dressing \_\_\_\_\_

Weight \_\_\_\_\_ kgs Specialised equipment required \_\_\_\_\_