BARCODE

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Royal Rehab
The Rehabilitation & Disability Support Network

Community Rehabilitation Service - Referral Form

FAMILY NAME _____ MRN _____
GIVEN NAME _____ ☐MALE ☐FEMALE
DoB _____/_____/_____ M.O._____
ADDRESS _____
_____
LOCATION/WARD _____
COMPLETE ALL DETAILS OR AFFIX CLIENT LABEL HERE

Date Referred:		**Expected Discharge Date:**
Clients Name:		**Medicare No:**
DOB:	**COB:**	**Sex:** ☐ Male ☐ Female
Address:		
Phone Number:		
Email:		
Interpreter Required: Yes/No		**Language:**
Contact Person:		**Relationship:**
Phone Number:		**Email address:**
General Practitioner:		**Phone:**
Address:		

Service Referring to:

☐ **Public Outpatients** Fax: (02) 8088 3895 Phone: (02) 9808 9218

☐ **Home Based Rehab*** Fax: (02) 8415 7122 Phone: (02) 9808 9687

* This is a multidisciplinary service

Please Tick services requested:

☐ Dietitian
☐ Neuropsychology (as required)
☐ Nursing
☐ Social Work
☐ Occupational Therapy
☐ Physiotherapy
☐ Speech Therapy
☐ Aquatic Physiotherapy

Relevant Health Information (Please attach medical/admission/discharge/medication summaries)

Client aware of referral? Yes/No

NO WRITING

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Royal Rehab
The Rehabilitation & Disability Support Network

Community Rehabilitation Service - External Referral Form

FAMILY NAME _____ MRN _____
GIVEN NAME _____ ☐MALE ☐FEMALE
DoB _____/_____/_____ M.O._____
ADDRESS _____
_____
LOCATION/WARD _____
COMPLETE ALL DETAILS OR AFFIX CLIENT LABEL HERE

Current Functional Status:

Self Care: ☐ Independent ☐ Assistance Required Equipment used:

Transfers: ☐ Independent ☐ Assistance Required Equipment used:

Mobility: ☐ Independent ☐ Assistance Required Equipment used:

Comments:

Communication issues: Yes/No If Yes, provide details:

Cognitive issues: Yes/No If Yes, provide details

Social issues: Yes/No If Yes, provide details:

Drug/Alcohol Issues? YES/NO **Challenging Behaviours?** YES/NO **Falls Risk:** YES/NO

Comments:

Reason for Referral:

Client Goals:

Any Other Services Involved / Organised for Client (include contact details):

Referring Agency:	**Name & Designation:**
Phone number:	**Contact email:**

CRS Office Use Only

Date Received:	*Date Admitted:*	*Code:*
CMS Clinic:		

NO WRITING