Royal Rehab Ryde

EMPOWERING INDEPENDENCE

FAMILY NAME _____ MRN_____

GIVEN NAME _____☐MALE ☐FEMALE

DoB_____/_____/____M.O._____

ADDRESS_____

_____

LOCATION/WARD_____

COMPLETE ALL DETAILS OR AFFIX CLIENT LABEL HERE

Community Rehabilitation Service - Referral Form

Service Referring to:

☐ **Public Outpatients** Fax: (02) 8088 3895 Phone: (02) 9808 9218
outpatients@royalrehab.com.au

☒ **Home Based Rehab*** Fax: (02) 8415 7122 Phone: (02) 9808 9687 cbrs@royalrehab.com.au

*This is a multidisciplinary service. Single referrals are not accepted for Home Based Rehab

Please Tick services requested:

☐ Dietitian
☐ Social Work
☐ Nursing
☐ Neuropsychology (Limited availability)
☐ Occupational Therapy
☐ Physiotherapy
☐ Speech Pathology
☐ Aquatic Physiotherapy (Outpatients Only)

Client aware of referral? ☐ Yes ☐ No

Date Referred:	**Expected Discharge Date:**
Clients Name:	**Medicare No:**

DOB:	**COB:**	**Sex:** ☐ Male ☐ Female

Is the client Aboriginal / Torres Strait Islander:

☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander
☐ Neither Aboriginal nor Torres Strait Islander ☐ Unknown

Address:	
Phone Number:	
Email:	
Interpreter Required: ☐ Yes ☐ No	**Language:**
Alternate Contact:	**Relationship:**
Phone Number:	**Email address:**
Preferred person to contact for appointments:	
General Practitioner:	**Phone:**
Address:	

Relevant Health Information (Attach PMHx medical/initial reason for admission to hospital/discharge/medication summaries)

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_____
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Current Functional Status:

Self-Care:	☐ Independent	☐ Assistance Required	Equipment used:
Transfers:	☐ Independent	☐ Assistance Required	Equipment used:
Indoor Mobility:	☐ Independent	☐ Assistance Required	Equipment used:
Outdoor Mobility:	☐ Independent	☐ Assistance Required	Equipment used:
Stairs:	☐ Independent	☐ Assistance Required	Equipment used:

Comments:

Orthopaedic Restrictions / Precautions (if relevant):

☐ WBAT ☐ Partial WB _____% ☐ Protected WB ☐ NWB ☐ Other _____

Date Commenced: Timeframe of restrictions:

Next ortho review date: Surgeon details:

Falls risk: ☐ Yes ☐ No If Yes, provide details:

Pressure Injury risk: ☐ Yes ☐ No If Yes, provide details:

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

Nutrition issues: ☐ Yes ☐ No

Weight _____kg Height _____cm Weight change in last 6-12 months _____

Recent loss of appetite ☐ Yes ☐ No If Yes, provide details:

Modified Diet ☐ Yes ☐ No If Yes, provide details:

Cognitive issues: ☐ Yes ☐ No If Yes, provide details:

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

Social situation:

Pre-existing mental health or drug and alcohol history that may impact on their rehab program? Please tick and outline below:

☐ Low mood	☐ Unstable Mood	☐ Anxiety/Panic attacks
☐ Low motivation	☐ Aggression	☐ Disinhibition
☐ Psychosis	☐ Drug and/or alcohol history	☐ Other… Provide details:

Comments:

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Community Rehabilitation Service - Referral Form

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:		

Information about the programs and eligibility are available on the Royal Rehab Ryde Group Public Services website