




BINDING MARGIN - DO NOT WRITE

 Ramsay Health Care	Rehabilitation Unit Pre-Admission & Referral Form	Surname: _____	
Rehab Unit Name/Contact/Fax No: _____		Given Name: _____	
		Address: _____	
		DOB: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
		(Affix Patient Identification label here, if available)	
REFERRAL DETAILS		Referring Dr:	
Referral to: (Optional)		(NIB only) Signature: _____	
<input type="checkbox"/> INPATIENT REFERRAL (assessed as requiring 24 hour nursing care)		Ph: _____	
<input type="checkbox"/> DAY PROGRAM REFERRAL (full day / half day)		Provider No: _____	
Referral Date: ____ / ____ / ____	Requested admission date: ____ / ____ / ____	Patient Ph: _____	
Person for notification: _____		Ph: _____ Relationship: _____	
Usual GP: _____	Medicare No.: _____	Exp: _____	
Patient Health Fund: _____	Health fund No.: _____	DVA No.: _____	
<input type="checkbox"/> Workers Comp <input type="checkbox"/> Third Party: If yes: Insurance Company: _____		Claim number: _____	
Case Manager: _____		Phone: _____	
Is the patient an existing NDIS participant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Application pending <input type="checkbox"/> Considering			
Pt Location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital: _____	Ward: _____	Bed: _____	Ward Phone: _____
Referrers Name: _____	Position: _____	Ward: _____	
Infectious Status (e.g.MRSA/VRE/ESBL/CRE positive):		Results - <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Indep <input type="checkbox"/> s/v <input type="checkbox"/> 1 Assist <input type="checkbox"/> 2 Assist <input type="checkbox"/> Immobile <input type="checkbox"/> Walking Aid (Type): _____ Distance: _____ m		
Transfers	<input type="checkbox"/> Indep <input type="checkbox"/> s/v <input type="checkbox"/> 1 Assist <input type="checkbox"/> 2 Assist <input type="checkbox"/> Standing Hoist <input type="checkbox"/> Full Hoist		
Weight bearing	<input type="checkbox"/> FWB <input type="checkbox"/> WBAT <input type="checkbox"/> Partial WB (____%) <input type="checkbox"/> TWB <input type="checkbox"/> NWB Date of next WB status review: ____ / ____ / ____		
Cognition	<input type="checkbox"/> Alert <input type="checkbox"/> Orientated <input type="checkbox"/> Confused <input type="checkbox"/> Wandering <input type="checkbox"/> Non-compliant MOCA / MMSE score (if done): _____		
Falls Risk	<input type="checkbox"/> At Risk <input type="checkbox"/> No risk No. falls in last 6 months: _____ No. falls during current admission: _____		
Continence	Bladder: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> IDC <input type="checkbox"/> SPC Weight _____ kg		
	Bowel: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent	Toileting	<input type="checkbox"/> Indep <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance
Showering	<input type="checkbox"/> Indep <input type="checkbox"/> Supervision <input type="checkbox"/> Assistance	Wounds	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify: _____
Diet	Communication		
Fluids	<input type="checkbox"/> Thin <input type="checkbox"/> Slightly Thick <input type="checkbox"/> Mildly Thick <input type="checkbox"/> Moderately Thick <input type="checkbox"/> Extremely Thick <input type="checkbox"/> Nil by Mouth		
Medication	<input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist required <input type="checkbox"/> PICC line <input type="checkbox"/> IV AB's		
Previous functional status			
REHABILITATION PLAN & GOALS			
Patient willingness and ability to comply with program?		<input type="checkbox"/> YES <input type="checkbox"/> 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.			