ST VINCENT'S PRIVATE HOSPITAL
MELBOURNE

EXTERNAL REHABILITATION REFERRAL

Given Names ____________________
Surname ____________________
DOB ____________________
UR Number ____________________
Sex ________ Room No ________

Please FAX to Werribee Rahabilitation: 9218-8165 / East Melbourne Rehabilitation: 9928-6744

DIAGNOSIS:	

Estimated Transfer Date:	Expected Length of Stay:

Address ______________________________ Suburb ____________________
Email ______________________________ Mobile ____________________
Country of Birth ____________________ Religion ____________________
Marital Status ____________________
GP Name ______________________________ GP Clinic ____________________
GP Phone No ____________________

Fund

☐ Private
Health Fund ______________
Member Number ______________

☐ DVA
Member Number ____________

☐ TAC
Claim Number __________
Case Manager __________

☐ Workcover
Approval Letter ________________

Medicare Card
Card No ______________________
Ref No ______________

For Office Use Only
Fund Check ☐ Excess ______________
Eligible for Rehab Admission ☐ Yes ☐ No
Note: ______________________________
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Referrer Details
Current Hospital UR Number ______________________________________
Referring Facility ____________________ Ward __________ Bed ________
Admission Date ____________________ Referral Date ____________________
Contact Person ____________________ Contact No. ____________________
Treating Specialist ______________________________________
Acute Admission Diagnosis ______________________________________

Clinical Assessment

English Proficiency ____________________
Hearing ____________________
Vision ____________________

Next of Kin/Emergency Contact

Name/Relationship ________________________________ Phone No. ________________________

Past Medical History	Current Medical History / Diagnosis (include investigations)

ACAT / ACAS Completed? ☐ Yes ☐ No Date ________________________

Advance Care Directive ☐ Yes ☐ No Details ________________________

Enduring Guardianship / EPOA ☐ Yes ☐ No

MRSA Screening ☐ Yes ☐ No Site ______________ Result __________________

Allergies / Alerts ____

Wound Details ____

Mobility ☐ Assist ☐ Mod ☐ Min ☐ With Aids Specify Aids ________________________

Distance ☐ 5-20m ☐ 50m ☐ 100m ☐ 200m

Weight Bearing Status ____

Transfers ____

Showering / Dressing ☐ Assist ☐ Mod ☐ Min ☐ Supervision ☐ Set-up

Toileting ____

Continence - Bladder ____

Continence - Bowel ____

Bowel last opened ____

Mental State ☐ Alert ☐ Confuse ☐ Wandering
☐ Inappropriate Behaviours Details: ___________

Diet ___________ Fluids ___________

Weight (Kgs) ___________

Bariatric equipment required ☐ Yes ☐ No Specify ___________

Falls Risk ☐ Low ☐ High

No. of falls in the last 12 months ___________

Pressure Injury ☐ Yes ☐ No Location ___________

Pre Morbid State

Mobility ☐ Assist ☐ Mod ☐ Min ☐ With Aids ☐ Nil aid

Distance ☐ 5-20m ☐ 50m ☐ 100m ☐ 200m

Weight Bearing Status ___________

Transfers ___________

Showering / Dressing ☐ Assist/Mod Assist ☐ Min ☐ Set-up ☐ Supervision ☐ Independent

Toileting ___________

Continence - Bladder ☐ Yes ☐ No ☐ IDC ☐ SPC

Continence - Bowel ☐ Yes ☐ No ☐ Stoma

Mental State ☐ Alert ☐ Confuse ☐ Wandering
☐ Inappropriate Behaviours

Expected to return to premorbid facility ☐ Yes ☐ No

Accomodation Details ☐ Single Storey House Other ___________
☐ Double Storey House

Living Arrangements ☐ Alone ☐ Spouse/Partner ☐ with Family
☐ Other, specify ___________

Access

Front - No of Steps ___________ Rail ☐ Yes ☐ No

Rear - No of Steps ___________ Rail ☐ Yes ☐ No

Internal Steps ___________

Bathroom

☐ Separate Shower

Rail ☐ Yes ☐ No

Toilet Rails ☐ Yes ☐ No Over Toilet Frame ☐ Yes ☐ No

HHSH ☐ Yes ☐ No Shower Chair ☐ Yes ☐ No

ADL's

Personal ADL's ___________ Domestic ADL's ___________

Community ADL's ___________ Driving Car ☐ Yes ☐ No

Services

☐ Home Help ☐ PCA ☐ Meals On Wheels

☐ Shopping ☐ ☐

Potential barriers to discharge ______________________________

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Submission

Primary reason for episode of care ______________________________

Assessed as suitable for program ______________________________

Provisional Impairment Code ______________________________

Patient Goals ☐ Improve Locomotion

☐ Improve transfers

☐ Improve personal care

Patient/family informed of expected clinical outcomes, and agree to admission ☐ Yes ☐ No

Ambulance booked ☐ Yes ☐ No By ______________ When __________

☐ Stretcher ☐ Wheelchair

Completed by ______________________________ Date ______________

Rehabilitation Physician Informed: ☐ Yes ☐ No Date ______________

Follow-up required: ☐ Yes ☐ No

Notes: ______________________________

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For any queries please contact Werribee - 9218 8293 / East Melbourne 9928 6966