ST VINCENT'S PRIVATE HOSPITAL
BRISBANE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

Affix patient label

Telephone: 07 3240 1213 Fax to: 07 3391 8902

REQUEST FOR ADMISSION TO ST VINCENT'S PRIVATE HOSPITAL BRISBANE

please do not write in the binding margin

Diagnosis:	Please attach draft Discharge Summary
Past Medical History:	
Referral to:	
☐ Inpatient Rehabilitation (complete Section B)	☐ Day Rehabilitation (complete Section B)
☐ Pain Management Day Program ☐ Medical ☐ Requires Infusion	☐ Expected length of stay .....
☐ Palliative Care Inpatient (complete Section C)	☐ In Home Palliative Care (please complete referral here: http://svphb.pal.care/referral)
☐ Interim Care	☐ Geriatric Management and Evaluation (complete Section B)
Patient Details: Please attach Demographic sheet with Patient details.	
Is there an Enduring Power of Attorney? ☐ Yes ☐ No ☐ N/K ☐ Copy sighted	If yes, please give details of nominated person & attach copy
Advanced Health Directive: ☐ Yes ☐ No ☐ N/K	
G.P. Name:	
Address:	
Telephone:	Fax:
Funding Details:	
☐ Private Fund:	Membership Number:
☐ Pensioner	Pension No:
☐ DVA	DVA number: DVA Gold ☐ DVA White ☐
☐ WorkCover / Third Party	
☐ Centrelink	Type Number
Medicare No:	Ref: Valid to: Safety Net Number:
Usual Pharmacy:	Contact No:
Referrer's Name:	**Date referred:**

SECTION A

Known Allergies: Approximate weight:
Other patient concerns (e.g. wandering/dementia/aggression) ☐ Yes ☐ No
Is the patient on OR been on Antithrombotic therapy ☐ Yes ☐ No Medication Chart attached ☐
Is the patient immunocompromised? ☐ Yes ☐ No
Is the patient's weight >140kg? ☐ Yes ☐ No Patient's weight? ..... Hoist ☐ Yes ☐ No
☐ PICC/IVC ☐ IDC
Is the patient receiving wound care management regime? ☐ Yes ☐ No
History of infection / colonisation with a multi-resistant organism ☐ Yes ☐ No
Site: ☐ Nose ☐ Wound ☐ Groin ☐ Rectal ☐ Faeces ☐ Other .....
☐ MRSA ☐ ESBL ☐ VRE ☐ CPE ☐ Other .....
Date diagnosed?
Has the patient experienced vomiting and/or diarrhoea in the last 2 weeks? ☐ Yes ☐ No
Illness diagnosed? ..... Does the patient still have diarrhoea? ☐ Yes ☐ No
Was the patient treated for this illness? ☐ Yes ☐ No
In the last 2 weeks, has the patient had influenza, cough, sore throat or a fever? ☐ Yes ☐ No If yes, please specify: .....
Has the patient returned from overseas in the last 14 days? ☐ Yes ☐ No
Has the patient had contact with a known case of, COVD-19 or flu-like symptoms? ☐ Yes ☐ No
Has the patient been transferred from a residential aged care facility? ☐ Yes ☐ No

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SECTION B

Section B to be completed for all patients EXCEPT those referred to Pain Management Program

Social Situation	☐ Lives alone ☐ Lives with Carer ☐ Residential Aged Care Facility ☐ Other
Cognition	☐ Alert ☐ Confused ☐ Short term memory loss ☐ Depression ☐ other
Communication	☐ Normal ☐ Deficit
Swallow	☐ Normal ☐ Impaired
Diet	☐ Normal ☐ Modified .....
Fluids	☐ Normal ☐ Thickened Level of thickening?

Activity	Assistance Required			Independent	Equipment/Aid	Comment
	2 person	1 person	Supervise			
Transfers						
Toileting						
Showering						
Dressing						
Mobility						
Eating						
Continence	☐ Continent ☐ Incontinent		☐ Urine	☐ Faeces	IDC Yes ☐ No ☐	

PATIENT GOALS FOR REHABILITATION

REHABILITATION INFORMATION

Patient requires 24 hour nursing care?	Yes ☐	No ☐
Has the patient experienced functional loss secondary to an acute event?	Yes ☐	No ☐
Is there reasonable expectation of functional gain?	Yes ☐	No ☐
Patient able to participate in up to 3 hours of rehabilitation daily for 5 days/week?	Yes ☐	No ☐
Patient understands and agrees to participate in the SVPHB rehabilitation program?	Yes ☐	No ☐
Patient is aware and agrees to the goals for rehabilitation and case conferences?	Yes ☐	No ☐
Admission is accepted by rehabilitation physician?	Yes ☐	No ☐

PALLIATIVE CARE INFORMATION

SECTION C

Please indicate the reason for seeking admission to Palliative Care

☐ Symptom management ☐ End of life care ☐ Other (please state)

Please include details of symptoms and principal palliative concerns/issues:

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Lock and Submit Form

Clear Form (both sides)