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

Patient Name:
Patient DOB:
Patient URN:

Alternatively, please affix patient label.

Telephone: 07 3240 1213 Fax to: 07 3319 5591

REQUEST FOR ADMISSION TO ST VINCENT' S

please do not write in the binding margin

Diagnosis: **Rehabilitation Referral**

Patient details: please attach copy of patient demographic

Presenting Complaint:

Outstanding medical issues (plan and follow up)

Is the patient:

An Orthopaedic patient: ☐ Yes ☐ No (If yes, please attach weight bear status and next review date)
A patient with wounds: ☐ Yes ☐ No (If yes, please attach wound and or Vac management plan and next review date)

Follow up:
Does the patient need any follow up appointments/ Outpatient appointments?
☐ Yes ☐ No (If yes please ensue that these have been booked and provide the details of these appointments/OPD including dates and times)
Does the patient need any procedures or Investigations?
☐ Yes ☐ No (If yes please ensue that these have been booked and provide these details)

Comprehensive Discharge summary Attached: ☐ Yes ☐ No
Must include medical history, rehabilitation goals and discharge destination

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

Is the patient on antibiotics: ☐ Yes ☐ No (If yes, please include length of time and step down plan)

Is the patient on OR been on Antithrombotic therapy ☐ Yes ☐ No (If yes, please include length of time and step down plan)

1/52 pathology results attached: ☐ Yes ☐ No
Is there any follow up needed: ☐ Yes ☐ No
If yes, please provide documentation including dates and times of follow up

Have there been any clinical Incidents with the patient (met calls/behavior etc) ☐ Yes ☐ No
If yes, please provide documentation

Does the patient have a Multi- resistant organism ☐ Yes ☐ No
If yes, please provide documentation

Other patient concerns (e.g. wandering/dementia/aggression/falls/communication) ☐ Yes ☐ No

Discharge medication list attached ☐ Yes ☐ No

Are there any cognition concerns : ☐ Yes ☐ No
If yes, Please attach MoCA

Does the patient have any previous psychiatric history: ☐ Yes ☐ No
If yes, please attach documentation

Is the patient immunocompromised? ☐ Yes ☐ No

Is the patient's weight >150kg? ☐ Yes ☐ No Patient's weight?

What was the patient's Pre-morbid Function

Activity	Assistance required			Independent	Equipment/aid	Comment
	2 person	1 person	Supervise			
Transfers						
Toileting						
Showering						
Dressing						
Mobility						

Eating						
Continence	D Continent D Incontinent		D Urine D Faeces		IDC D Yes D No	Yes D

Other comments:

Is the patient engaging with allied health: ☐ Yes ☐ No

Please provide documentation to support response

What is the patient goal for rehabilitation admission:

REHABILITATION INFORMATION
Patient requires 24 hour nursing care?
Has the patient experienced functional loss secondary to an acute event?
Is there reasonable expectation of functional gain?
Patient able to participate in up to 3 hours of rehabilitation daily for 5 days/week?
Patient understands and agrees to participate in the SVPHB rehabilitation program?
Patient is aware and agrees to the goals for rehabilitation and case conferences?
Admission is accepted by rehabilitation physician?

G.P. Name: **Practice:**

Funding Details:

☐ Private Fund: Membership Number:

☐ Pensioner Pension No:

☐ DVA DVA number: DVA Gold ☐ DVA White ☐

☐ WorkCover / Third Party

Medicare No: Ref: Valid to: Safety Net Number:

Once complete, please email referral to SVHB Admissions Mail svhbadmissions@svha.org.au

For all MSH public referrals please send direct to the MSH additional beds platform mshadditionalbeds@health.qld.gov.au