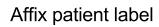
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A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

ST VINCENT'S PRIVATE HOSPITAL

icicp	110116: 07 0270 1210 1 ax to: 07 0019 0001	
Diag	nosis:	Please attach draft Discharge Summary
Past	Medical History:	
Refe	ral to:	
☐ Inp	patient Rehabilitation (complete Section B)	ilitation (complete Section B)
☐ Pa	in Management Day Program	Expected length of stay
	lliative Care Inpatient	referral here: http://svphb.pal.care/referral)
☐ Int	erim Care Geriatric Management and Evaluation (con	nplete Section B)
Patie	nt Details: Please attach Demographic sheet with Patient details.	
Is the	re an Enduring Power of Attorney?	copy sighted ated person & attach copy
Advar	nced Health Directive: Yes No N/K	
G.P. I	Name:	
Addre	SS:	
Telepl	none: Fax:	
Fund	ing Details:	
☐ Pri	vate Fund: Membership Number:	
☐ Pe	nsioner Pension No:	
	A DVA number:	DVA Gold DVA White
☐ Wo	orkCover / Third Party	
Се	ntrelink Type Numb	er
Media	are No: Ref: Valid to:	Safety Net Number:
Usual	Pharmacy: Contact No:	
Refe	rer's Name:	Date referred:
	Known Allergies: Appro	oximate weight:
S E	Other patient concerns (e.g. wandering/dementia/aggression)]Yes □ No
Ċ	Is the patient on OR been on Antithrombotic therapy Yes No Med	dication Chart attached
T	Is the patient immunocompromised?	
o	Is the patient's weight >140kg? \square Yes \square No Patient's weight	? Hoist Yes No
N	□ PICC/IVC □ IDC	
Α	Is the patient receiving wound care management regime?	s 🗆 No
	History of infection / colonisation with a multi-resistant organism	s 🗆 No
	Site: Nose Wound Groin Rectal Faeces Oth	er
	☐ MRSA ☐ ESBL ☐ VRE ☐ CPE ☐ Other	
	Date diagnosed?	
	Has the patient experienced vomiting and/or diarrhoea in the last 2 weeks?	s 🗆 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
	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? $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$	□No



Affix patient label

S E C T I O N B	Section B to b Social Situation	Lives alone	Lives wit	h Carer □ R	esidential Aged Care F	acility Other		
	Cognition			Short term mei				
	Communication	Normal Deficit						
	Swallow	□ Normal □ Impaired						
	Diet	□ Normal □ Modified						
	Fluids	□ Normal □ Thickened Level of thickening?						
		As	sistance Requ					
	Activity	2 person	1 person	Supervise	Independent	Equipment/Aid	Comment	
	Transfers							
	Toileting							
	Showering							
	Dressing							
	Mobility							
	Eating							
	Continence	☐ Continent		☐ Urine	Faeces	IDC Yes□ N	o 🗆	
		LI Incontinent	PATIEN	NT GOALS FO	R REHABILITATIO	DN		
		LI Incontinent	PATIEN	NT GOALS FO	R REHABILITATIO	DN		
		LI Incontinent			R REHABILITATIO	DN		
	Patient requires		REI			Yes	No □	
	Patient requires Has the patient	24 hour nursin	RE l ng care?	HABILITATION	I INFORMATION			
	ļ	24 hour nursin experienced fu	RE I g care? ınctional loss s	HABILITATION secondary to ar	I INFORMATION	Yes [□ No □	
	Has the patient Is there reasona	24 hour nursin experienced fu	REIng care? Inctional loss s	HABILITATION secondary to ar gain?	I INFORMATION	Yes [Yes [Yes [No No	
	Has the patient Is there reasona Patient able to p	24 hour nursin experienced fu able expectation participate in up	REIng care? Inctional loss son of functional to 3 hours of	HABILITATION secondary to ar gain? rehabilitation c	I INFORMATION acute event?	Yes [Yes [Yes [Yes [No No No	
	Has the patient Is there reasona Patient able to p Patient understa	24 hour nursin experienced fu able expectation participate in up ands and agree	REI ng care? unctional loss s n of functional to to 3 hours of the ses to participat	HABILITATION secondary to ar gain? frehabilitation contention in the SVPHE	I INFORMATION acute event? aily for 5 days/weel	Yes [Yes [Yes [Yes [Yes [Yes] Yes [Yes [Yes]	No No No	
	Has the patient Is there reasona Patient able to p Patient understa	24 hour nursin experienced further than the expectation participate in upands and agrees and agrees to	REI g care? Inctional loss so n of functional to to 3 hours of es to participat the goals for r	HABILITATION secondary to ar gain? rehabilitation coe in the SVPHE	I INFORMATION acute event? aily for 5 days/weeks rehabilitation progr	Yes [Yes [Yes [Yes [Yes [Yes] Yes [Yes [Yes]	No No No No No No No	
	Has the patient Is there reasona Patient able to p Patient understa Patient is aware	24 hour nursin experienced fu able expectation participate in up ands and agrees and agrees to cepted by reha	REI g care? Inctional loss so n of functional to to 3 hours of es to participat the goals for rebilitation phys	HABILITATION secondary to ar gain? rehabilitation coe in the SVPHE rehabilitation ar ician?	acute event? aily for 5 days/weels rehabilitation prograd case conferences	Yes [No No No No No No No	