



Affix patient label

Telephone: 07 3240 1213 Fax to: 07 3319 5591

Diagnosis:		Please attach draft Discharge Summary		
Past Medical History:				
Referral to:				
<input type="checkbox"/> Inpatient Rehabilitation (complete Section B)		<input type="checkbox"/> Day Rehabilitation (complete Section B)		
<input type="checkbox"/> Pain Management Day Program		<input type="checkbox"/> Medical	<input type="checkbox"/> Requires Infusion	
<input type="checkbox"/> Palliative Care Inpatient (complete Section C)		<input type="checkbox"/> In Home Palliative Care (please complete referral here: http://svphb.pal.care/referral)		
<input type="checkbox"/> Interim Care		<input type="checkbox"/> Geriatric Management and Evaluation (complete Section B)		
Patient Details: Please attach Demographic sheet with Patient details.				
Is there an Enduring Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/K <input type="checkbox"/> Copy sighted If yes, please give details of nominated person & attach copy				
Advanced Health Directive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/K				
G.P. Name:				
Address:				
Telephone:		Fax:		
Funding Details:				
<input type="checkbox"/> Private Fund:		Membership Number:		
<input type="checkbox"/> Pensioner		Pension No:		
<input type="checkbox"/> DVA		DVA number: DVA Gold <input type="checkbox"/> DVA White <input type="checkbox"/>		
<input type="checkbox"/> WorkCover / Third Party				
<input type="checkbox"/> 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)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is the patient on OR been on Antithrombotic therapy <input type="checkbox"/> Yes <input type="checkbox"/> No		Medication Chart attached <input type="checkbox"/>	
	Is the patient immunocompromised? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Is the patient's weight >140kg? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient's weight?	Hoist <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> PICC/IVC <input type="checkbox"/> IDC			
	Is the patient receiving wound care management regime?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	History of infection / colonisation with a multi-resistant organism		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Site: <input type="checkbox"/> Nose <input type="checkbox"/> Wound <input type="checkbox"/> Groin <input type="checkbox"/> Rectal <input type="checkbox"/> Faeces <input type="checkbox"/> Other			
	<input type="checkbox"/> MRSA <input type="checkbox"/> ESBL <input type="checkbox"/> VRE <input type="checkbox"/> CPE <input type="checkbox"/> Other			
	Date diagnosed?			
	Has the patient experienced vomiting and/or diarrhoea in the last 2 weeks?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Illness diagnosed?		Does the patient still have diarrhoea? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Was the patient treated for this illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	In the last 2 weeks, has the patient had influenza, cough, sore throat or a fever?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please specify:				
Has the patient returned from overseas in the last 14 days?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the patient had contact with a known case of, COVID-19 or flu-like symptoms?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the patient been transferred from a residential aged care facility?		<input type="checkbox"/> Yes <input type="checkbox"/> No		

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Section B to be completed for all patients EXCEPT those referred to Pain Management Program							
SECTION B	Social Situation	<input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with Carer <input type="checkbox"/> Residential Aged Care Facility <input type="checkbox"/> Other					
	Cognition	<input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Short term memory loss <input type="checkbox"/> Depression <input type="checkbox"/> other					
	Communication	<input type="checkbox"/> Normal <input type="checkbox"/> Deficit					
	Swallow	<input type="checkbox"/> Normal <input type="checkbox"/> Impaired					
	Diet	<input type="checkbox"/> Normal <input type="checkbox"/> Modified					
	Fluids	<input type="checkbox"/> Normal <input type="checkbox"/> Thickened Level of thickening?					
	Activity	Assistance Required			Independent	Equipment/Aid	Comment
		2 person	1 person	Supervise			
	Transfers						
	Toileting						
Showering							
Dressing							
Mobility							
Eating							
Continence	<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent		<input type="checkbox"/> Urine <input type="checkbox"/> Faeces		IDC Yes <input type="checkbox"/>	No <input type="checkbox"/>	
PATIENT GOALS FOR REHABILITATION							
REHABILITATION INFORMATION							
Patient requires 24 hour nursing care?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Has the patient experienced functional loss secondary to an acute event?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is there reasonable expectation of functional gain?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Patient able to participate in up to 3 hours of rehabilitation daily for 5 days/week?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Patient understands and agrees to participate in the SVPHB rehabilitation program?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Patient is aware and agrees to the goals for rehabilitation and case conferences?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Admission is accepted by rehabilitation physician?					Yes <input type="checkbox"/>	No <input type="checkbox"/>	
PALLIATIVE CARE INFORMATION							
SECTION C	Please indicate the reason for seeking admission to Palliative Care						
	<input type="checkbox"/> Symptom management <input type="checkbox"/> End of life care <input type="checkbox"/> Other (please state)						
Please include details of symptoms and principal palliative concerns/issues:							

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