President Private HOSPITAL

TELEPHONE: 02 9521 7788 (Inpatients)
02 9542 0364 (Day Rehabilitation)
FAX: 02 9545 5284
EMAIL: pphenquiries@machealth.com.au

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME	
GIVEN NAMES	
D.O.B.	SEX
WARD	DOCTOR
UNIT NUMBER	

REHABILITATION REFERRAL

PROGRAM: ☐ **INPATIENT** ☐ **DAY ONLY REHABILITATION** Full day ☐ Half day ☐
(Requiring 24hr nursing care)

1. PATIENT DETAILS:

Patient's name: _____ DOB:_____/_____/_____ Age:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ W ☐ D ☐ Single room requested

Are you of Aboriginal and/or Torres Strait Island Origin? ☐ Yes ☐ No

Address: _____

Telephone:_____ Religion: _____ Country of birth: _____

Next of kin: _____ Relationship: _____ Telephone: _____

Medicare No.: _____ Expiry date: _____ Pension No.: _____

Private Health Fund:_____ Membership: _____

Is this injury a result of an accident? ☐ Yes ☐ No If Yes, is the claim accepted? ☐ Yes ☐ No

WC/CTP Insurance Co.:_____ Claim No.:_____

Case Manager: _____ Telephone: _____

2. REFERRAL DETAILS:

Expected date of admission to PPH:_____/_____/_____ Previous patient at PPH: ☐ Yes ☐ No Year: _____

Date of Referral:_____/_____/_____ Person referring:_____ Expected length of stay:_____

Expected D/C destination: _____

Referring from: a) Community settings _____ b) Hospital:_____

Referral hospital:_____ Ward: _____ Telephone: _____

Referring specialist: _____ Telephone: _____

Specialist Rooms address: _____

Infectious status. MRSA | VRE | CPE | CRE | Respiratory Date of recent positive results _____/_____/_____
Other:_____ Please provide copy with referral

GP: _____ Telephone:_____ Fax: _____

GP address:_____

Preferred Rehabilitation Specialist: _____

3. CLINICAL DETAILS:

Diagnosis/Operation: _____ Operation date:_____/_____/_____

Ongoing treatment: Dialysis | Chemo | Radiotherapy | Infusions

Relevant history: _____

_____

Current medications: _____

_____

Allergies: _____

REHABILITATION REFERRAL

MR 6B SEP 2023

BINDING MARGIN – DO NOT WRITE

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REHABILITATION REFERRAL

3. CLINICAL DETAILS:

CURRENT PHYSICAL AND MENTAL STATUS

Communication: ☐ Alert ☐ Orientated ☐ Co-operative ☐ Confused ☐ Dementia

Language spoken at home: _____ Interpreter required: Yes / No

Mobility: ☐ W/C ☐ FASF ☐ Rollator/PUF ☐ Stick/s
☐ Crutches ☐ Independent ☐ Minimum assist ☐ Moderate assist ☐ Supervision

ADL's: ☐ Independent ☐ Supervision ☐ Moderate assist ☐ Minimal assist
☐ Full assist ☐ Aids:_____

Type of aids: ☐ FWB ☐ WBAT ☐ PWB ☐ TWB ☐ NWB (for _____ wk)

Continence: ☐ Continent ☐ Incontinent Urine ☐ Incontinent Faeces
☐ SPC ☐ IDC ☐ Bowel regeime

Feeding: ☐ Self ☐ Assist ☐ NGT ☐ PEG ☐ Fluid restriction
☐ Diet:_____ Fluids: Normal | Mild | Moderate | Fully Thick

Skin integrity: ☐ Intact ☐ Wound ☐ Pressure areas ☐ Ulcers
☐ Dressing Regeime: _____

Physical: ☐ Weight (kgs):_____ ☐ Hb:_____ ☐ Date last taken:_____/_____/_____

Specialist equipment: ☐ Yes ☐ No ☐ If Yes, equipment: _____

Social situation: ☐ Home ☐ Self Care Unit ☐ Hostel ☐ Nursing Home

Pre-Admission support: ☐ Self ☐ Live-in Spouse/Carer ☐ Community Service ☐ Non Live-in Care

Level of Function: ☐ Oxygen Current ACAT Assessment: Yes / No Date: _____

Rehabilitation Goals: (in conjunction with patient & family)
1: _____
2: _____
3: _____

PLEASE NOTE:

When a patient is transferred to **The President Private Hospital**, please ensure the following accompanies the patient:

- ☐ Appropriate discharge summaries (medical, nursing, allied health, list of medications, etc).
- ☐ Three days of medications supply.
- ☐ Details of follow-up appointment.
- ☐ Copies of report of relevant investigations (X-rays, pathology).

THE PRESIDENT PRIVATE HOSPITAL OFFICE USE ONLY: HFC ☐ Program Type _____

Telephone Assessment conducted: ☐ Yes ☐ No Date:_____/_____/_____

Contact: _____ Telephone: _____

Face to Face Assessment conducted: ☐ Yes ☐ No Date:_____/_____/_____

Patient agrees to transfer to the **The President Private Hospital**, if accepted: ☐ Yes ☐ No

Patient aware of, and agrees to, participate in therapy: ☐ Yes ☐ No

Patient informed of costs/health fund excess or co-payment (if applicable) and other charges such as Allied Health/Transport to and from the hospital: ☐ Yes ☐ No

Additional information: _____

Confirmed date of admission: _____/_____/_____ Specialist accepted: _____

Assessor:_____ Signed: _____ Date:_____/_____/_____

REHABILITATION REFERRAL MR 6B SEP 2023