mater health

REHABILITATION REFERRAL

Facility: Rockhampton Private Hospital

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

CQR0003

Mater Hospital Rockhampton, Rehabilitation Unit, Ward Street, Rockhampton, Qld 4700
For referral enquiries: Phone: 4931 3370, Email: rockhamptonrehab@mercycg.com
Return completed referral to: Fax: 4931 3364

Referral Information

Referral to: ☐ **Dr Dhiraj Saini** (Geriatrician) ☐ **Dr Paul Finighan** (Rehab Physician)

Date of referral:	Date of original hospital admission:
Referring from: ☐ Home ☐ Hospital:	Ward: .....
Person referring: PN	Contact number: /
Referring Specialist/GP:	
Provider number:	Specialist/GP signature:
Patient aware of, and agreeable to, referral: ☐ Yes ☐ No	
Private health fund:	Member number:

Medical Information

Diagnosis/operation:	Operation date:

Relevant medical history:

Current medications: ☐ Webster pack

Allergies: ☐ Nil known

Past medical history:

Social Information

Usual accommodation: ☐ Home ☐ Unit ☐ Hostel ☐ Nursing home ☐ Other *(specify)*: .....
Lives: ☐ Alone ☐ With spouse/partner ☐ Other *(specify)*: .....
Current ACAT: ☐ No ☐ Yes – Level: ◯ High ◯ Low

Support services received prior to presentation:

Social issues that may impact discharge:

Cognitive Status

☐ Alert ☐ Oriented ☐ Cooperative ☐ Dementia ☐ Delirium ☐ Night confusion

Mobility/Transfers

Previous function: ☐ Independent ☐ Supervision ☐ Minimal assist ☐ Moderate assist ☐ Full assist ☐ Aid: .....
Current function: ☐ Independent ☐ Supervision ☐ Minimal assist ☐ Moderate assist ☐ Full assist ☐ Aid: .....

Weight bearing status: ☐ FWB/WBAT ☐ PWB ☐ TWB ☐ NWB (for ..... more weeks)

ADL's

☐ Independent ☐ Supervision ☐ Minimal assist ☐ Moderate assist ☐ Full assist

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AFFIX PATIENT IDENTIFICATION LABEL HERE

Continence

Urinary: ☐ Continent ☐ Occasionally incontinent ☐ Incontinent ☐ IDC ☐ SPC

Faecal: ☐ Continent ☐ Occasionally incontinent ☐ Incontinent ☐ Colostomy ☐ Ileostomy

Swallow/Nutrition

Nutrition: ☐ NGT ☐ PEG ☐ Diabetic ☐ Other *(specify)*: .....

Food: ☐ Full ☐ Soft ☐ Minced/moist ☐ Puree

Fluid: ☐ Regular ☐ Mildly thick ☐ Moderately thick ☐ Extremely thick

Communication

☐ Aphasia (different understanding/producing language) ☐ Dysarthria (slurred speech)

Comments: .....

Infectious Precautions

☐ Nil ☐ VRE ☐ MRSA ☐ ESBL ☐ Other *(specify)*: ..... Site:

Skin Integrity

Wound: ☐ Yes ☐ No | Pressure injury: ☐ Yes ☐ No If Yes, grade: .....

Location: | Dressing:

Need for pressure relieving mattress: ☐ Yes ☐ No

Falls Risk

High falls risk: ☐ Yes ☐ No | Recent falls: ☐ Yes ☐ No

Expected Outcomes of Rehabilitation

Improvement of:

☐ Cognitive skills ☐ Gait mobility/balance ☐ Strength/fitness ☐ Pain management

☐ Communication/swallow ☐ Joint mobility/flexibility ☐ Functional independence/ADL's ☐ Other *(specify)*: .....

Other Relevant Information

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Date received:	Accepting MO:
Date accepted:	Health fund: ☐ Cover check
Admission date:	Diagnosis:
Time: ..... hours Bed:	Type: ☐ Medical ☐ Rehab recon ☐ Rehab neuro ☐ Rehab ortho UL ☐ Rehab ortho LL