PENINSULA HEALTH
Community & Continuing Care

EXTERNAL REFERRAL FOR SUB ACUTE ADMISSION

Referral for: ☐ Inpatient Rehabilitation ☐ Geriatric Evaluation & Management

UR NUMBER...

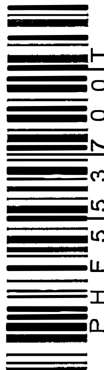
SURNAME...

GIVEN NAMES...

DATE OF BIRTH .... ☐ Male ☐ Female

Please fill in if no Patient Label available

Trial 17/11/10 Print Code14443



Subacute Assessment Service: Phone 9784 3071 Fax 9784 2313

☐ Private health Insurance Details .... ☐ Work cover ☐ TAC ☐ DVA ☐ Not insured

Referring Hospital.. Ward........... NUM.............. Contact ....

Social Situation ☐ Lives Alone ☐ Lives with .... ☐ Provides care for another person

☐ Supported Residential Care ☐ Low Level Res. Care ☐ High Level Res. Care ☐ Other ....

Next of Kin:

1. Name.. Phone No. ....
2. Name.. Phone No. ....

Do the patient / carer have an understanding about the reason for admission to sub acute care? ☐ Yes ☐ No

Comments

Interpreter required ☐ No ☐ Yes - Language required ....

Presenting Problems / Diagnosis / Surgery details	Past History

Medications of Significance: Please fax current Medication Chart

☐ Anticonvulsants ☐ Insulin ☐ Narcotic Analgesia ☐ Warfarin ☐ Heparin ☐ Clexane ☐ Prednisolone ☐ Antipsychotic

Current Pathology faxed with referral ☐ Yes ☐ No

Investigations:	**Faxed:**
☐ Xray	☐
☐ ECG	☐
☐ EEG	☐
☐ CT	☐
☐ U/S	☐
☐ MRI	☐
☐ Doppler	☐
☐ Other	☐

Specific Care needs for consideration:

☐ Skin Integrity ☐ Wound ☐ Weight Bearing Status

☐ Oxygen Therapy ☐ NFR ☐ Falls Risk

☐ Infection Control ☐ PICC Line ☐ Wandering Behaviours

☐ PEG Feeds ☐ BSL ☐ Bariatric Weight.........kg

Specify Bariatric equipment required

....

....

Comments / Other Issues

Follow up Appointments

PTO to page 2

TRIAL MR/53700

PATIENT NAME:
UR NO.

	Previous Level of Function	Current Level of Function
Mobility		
Transfers - bed/chair/toilet		
Continence		
Hygiene		
Dressing		
Eating / Nutrition		
Communication		
Cognition		
Vision		
Hearing		

Problem List

☐ Changes to mobility

Specify...

☐ Dependence on Mobility Aids

☐ Difficulty with transfers

☐ Falls

☐ Assist with personal hygiene, dressing and grooming

☐ Cognitive decline ☐ Acute ☐ Chronic

☐ Pain

☐ Bariatric

☐ Surgical wound

☐ Other...

OBSERVATIONS

BP ..../....... HR........ RR .... SaO2 ....O2 req ......T ....

Vital signs are normal and have been stable for 24 hours

☐ Yes ☐ No

Medically stable ☐ Yes ☐ No

Plan / Goals

Goals to be achieved in Sub-Acute setting:

☐ Optimise mobility and function

☐ Pain management

☐ Cognitive Assessment

☐ Assess appropriate discharge destination

Anticipated Discharge Destination:

☐ Home ☐ LLC ☐ HLC ☐ Other.........................

Patient goals post Rehabilitation / GEM..............................

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Significant change to medication has occurred in the past 24 hours ☐ Yes ☐ No

The patient will require medical review in the next 24 hours ☐ Yes ☐ No

CLINICAL RECOMMENDATION: ☐ Inpatient Rehabilitation ☐ Geriatric Evaluation and Management

Patient / NOK site preference ☐ GLR ☐ TMC ☐ RRU

Estimated Length of Stay: ☐ 5 - 7 days ☐ 1 - 2 weeks ☐ 2 - 3 weeks ☐ 3 - 4 weeks

☐ Over 4 weeks - Specify ....

Signature: .... Print Name:... Designation:.............. Date/Time: ....