



# Latrobe Regional Health

## Gippsland Health Service Inpatient Sub Acute Care Services Referral

LRH Fax Numbers: **REHAB:** (03) 5173 8135 **GEM:** (03) 5173 8329

Name	_____
Address	_____ _____ _____
Phone	_____
D.O.B.	_____ Sex: Male/Female
MRN	_____
GP:	_____
<b>Affix Bradma Label Here</b>	

**Referral to: Health Service :** \_\_\_\_\_  
**Bed Type (i.e. Rehab / GEM / Other) :** \_\_\_\_\_

**Referrer Details**

Organisation: \_\_\_\_\_ Date of Referral: \_\_\_\_\_  
Unit: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Alternate Contact Number: \_\_\_\_\_  
Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_  
Name, Designation of Referrer: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient's Medical Details at Referral**

Anticipated date of transfer to Sub-Acute Care: \_\_\_\_\_ Date of Acute Onset: \_\_\_\_\_  
Diagnosis / Medical Notes or Presenting illness: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Any Ongoing Acute Medical Issues: \_\_\_\_\_  
\_\_\_\_\_  
Past Medical / Psych History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Allergies: \_\_\_\_\_

**Consent**

Does the patient consent to referral?  
 Yes     No    If no, why? \_\_\_\_\_

**Infections**

Please identify if the patient has any infectious risks:  
 MRSA     VRE     CPE     Other, Specify \_\_\_\_\_

**Patient Details**

**Name of NOK** \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
**Contact** (If different from NOK) \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone: \_\_\_\_\_

**Guardian / Administrator**

**Power of Attorney**     Yes     No  
Details: \_\_\_\_\_  
Case Manager: \_\_\_\_\_  
Care Package Type: \_\_\_\_\_  
 Work Cover No: \_\_\_\_\_  
Private Health     Yes     No

**Patient Goals and Expectations:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Advanced Care Planning**

Does the patient have an Advanced Care Directive?

Yes     No    Details \_\_\_\_\_

**Anticipated Discharge Destination Post Inpatient Rehabilitation / GEM**

Home     Other \_\_\_\_\_

ACAS assessment – Date: \_\_\_\_\_ Residential Care:     Low Level     High Level

**Social / Family Supports Lives:**

Alone     Family     Other: \_\_\_\_\_

House     Flat / Unit     Aged Care Facility     Other \_\_\_\_\_

**Previous Services Received:**

MOW     Home Care     District Nursing     Other \_\_\_\_\_

**Please comment on patient’s level of function prior to this event (i.e. ADLs, mobility etc.):**

\_\_\_\_\_  
\_\_\_\_\_

**Current Physical Function**

**Weight Bearing Status**

Non WB     Touch WB     Partial WB     WB as tolerated     Full WB

High     Medium     Low

**Recent Falls:** \_\_\_\_\_

**High Risk Strategies (i.e. Exit Alarm, Visual Observations)** \_\_\_\_\_

**Mobility / Transfers**     Independent     Supervision     Assist     Dependent

Aids: \_\_\_\_\_ Endurance: \_\_\_\_\_

Own Equipment:     Yes     No

**Activities of Daily Living**     Independent     Supervision     Assist     Dependent

Details of Assistance/Supervision required: \_\_\_\_\_

Other Physical Issues: \_\_\_\_\_

**Nutrition / Diet**

Weight: \_\_\_\_\_ Date: \_\_\_\_\_

Dietary Requirements:     Full Ward Diet     Modified Diet     Enteral Feeding     Other

Details: \_\_\_\_\_

### Cognition / Behaviour

Are there any Cognitive Concerns:  No  Yes Are there any Behavioural Concerns:  No  Yes

Details: \_\_\_\_\_  
\_\_\_\_\_

Does patient exhibit any withdrawal symptoms:  No  Yes Details: \_\_\_\_\_

Does the patient require Visual Obs / Exit Alarm  No  Yes Details: \_\_\_\_\_

Cognitive Assessment: \_\_\_\_\_ Score: \_\_\_\_\_ Date: \_\_\_\_\_ Report Attached

Neuropsychiatric Cognitive Assessment (NUCOG) Score: \_\_\_\_\_ Date: \_\_\_\_\_ Report Attached

### Communication

Is there any communication difficulties?  No  Yes Details: \_\_\_\_\_

Is English the patient's first language?  No  Yes Details: \_\_\_\_\_

### Elimination

Bladder:  Continent  Incontinent  Catheter  Other \_\_\_\_\_

Bowels:  Continent  Incontinent  Stoma  Other \_\_\_\_\_

Continence Aids used: \_\_\_\_\_

### Skin Integrity / Wounds

Location: \_\_\_\_\_ Aetiology: \_\_\_\_\_ Duration: \_\_\_\_\_

Acute  Chronic Further Pressure Area Stage:  1  2  3  4  Unstageable  N/A

Details \_\_\_\_\_ Report Attached

### Medications

List of current medications and recent medication changes: (*Attaching copy of current drug chart and Medication Reconciliation Form / Medication Management Plan will suffice*)

\_\_\_\_\_  
\_\_\_\_\_ Charts Attached

### Special Treatment and Equipment Needs *(Please provide details)*

Dialysis \_\_\_\_\_  IV Therapy / Antibiotics \_\_\_\_\_

Bariatric \_\_\_\_\_  Oxygen \_\_\_\_\_

Other (Braces, Splints, Orthosis, Prosthesis, Pressure Equipment etc.) \_\_\_\_\_

### Follow Up Tests / Appointments

Date	Time	Test / Appointment	Location

**IMPORTANT** - Please ensure that all relevant supporting documents are attached to the referral (Allied Health Assessments, Medication Chart / Reconciliation Form, Recent Pathology, Discharge Summary etc.)

### OFFICE USE ONLY:

Date Referral Received: \_\_\_\_\_ Date of Acceptance (if applicable) \_\_\_\_\_

Outcome of Referral \_\_\_\_\_

Name & Designation \_\_\_\_\_ Signed \_\_\_\_\_