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: ______________________

Affix Bradma Label Here

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 ____________