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| **Patient Details:**  | **Date of referral:**  |  **Gender: F or M** |
| **Name:** | **Address:** |
| **Phone number:** | **DOB:**  | **Preferred Language:**  |
| **Interpreter required: Yes No** | **Has consent been obtained from Patient/Person responsible for referral? Yes No** |
| **If patient unable to provide consent/accurate clinical information, contact person:****Phone Number:** |
| **Nominated Next of Kin/Contact Person:**  | **Case Manager:**  |
| **Relationship/PoA:**  | **Phone Number:** |
| **Contact number:** | **Community Package:**  |
| **Referrer Details:** |
| **Relationship to patient:** |
| **Name:** |
| **Address/Organisation:** |
| **Phone Number:**  | **Fax Number:** |
| **GP (if not referral source):**  | **Contact number:** |
| **Current treating Doctor:** | **Contact number:** |
| **Person to contact to arrange admission:** | **Phone Number:** | **Contact days/time:** |
| **Person to contact to discuss clinical details, if required:** | **Phone Number:** | **Contact days/time:** |
| **Current admission to hospital, including problem/diagnosis/treatment/prognosis (include dates of admission and procedures):** |
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| **Relevant past medical history:** |
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| **Expectations/Goals of Sub Acute admission. Does this align with the patient/others expectations?:**  |
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| **Follow up specialist input or outpatients follow up:** |
| **Name:** | **Specialty:** | **Review Date:** | **Contact Number:** |
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| **Equipment needs/Special Requirements:** Please circle and comment |
| **Infection control Status: VRE Van A VRE Van B CPE MRSA Other:** **Has the patient been admitted overnight to any overseas hospital or residential facility within the last 12 months?** |
| **Secure Environment/Abscond Risk:** | **Single Room/Room for decreased stimulation:**  |
| **Behaviour: 1:1 Nurse Verbal Aggression Physical Aggression antipsychotic/behavioural Mx medication Other:**  |
| **Bariatric Equipment:** |
| **Falls Management: Falls Alarm High low bed 1:1 monitoring Other:**  |
| **Pressure Injury prevention: Air Mattress Heel Wedge Roho Cushion Other:**  |
| **Wounds and location (please send copies of wound care plan and regime):** |
| **Other identified risks/Equipment needs:**  |

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| **Pre morbid level of function:**  | **Current level of function:**  |
| **Mobility :** Indep S/V Assist Dependent**Gait Aid:**  | **Mobility:** Indep S/V Assist Dependent**Gait Aid:**  |
| **ADLs:** Indep S/V Assist Dependent**Comment:**  | **ADLs:** Indep S/V Assist Dependent**Comment:**  |
| **Cognitive issues:**  | **Cognitive issues:** |
| **Continence:**  | **Continence:**  |
| **Living Arrangements:**  |  **Continence Aids:** Indep S/V Assist Dependent **Type:**  |
| **Services:**  |  **Nutrition/Diet:** |
| **Date ready for transfer:** | **Anticipated discharge destination: Home SRS Residential Care Other:** |
| **Stream:** |  **GEM Rehabilitation Day Respite** |

**Please attach:** list of current medications □ Discharge summary □

Relevant investigations (pathology/radiology) □ Advanced care plan directives □