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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 □