



BINDING MARGIN - DO NOT WRITE

 Ramsay Health Care	Rehabilitation Unit Pre-Admission & Referral Form	Surname: _____	
Rehab Unit Name/Contact/Fax No: _____		Given Name: _____	
		Address: _____	
		DOB: _____ Sex: ☐ M ☐ F <i>(Affix Patient Identification label here, if available)</i>	
REFERRAL DETAILS		Referring Dr:	
Referral to: (Optional)		(NIB only) Signature: _____	
☐ INPATIENT REFERRAL (assessed as requiring 24 hour nursing care)		Ph: _____ Provider No: _____	
☐ DAY PROGRAM REFERRAL (full day / half day)			
Referral Date: _____	Requested admission date: _____	Patient Ph: _____	
Person for notification: _____		Ph: _____	Relationship: _____
Usual GP: _____	Medicare No.: _____	Exp: _____	
Patient Health Fund: _____	Health fund No.: _____	DVA No.: _____	
☐ Workers Comp ☐ Third Party: If yes: Insurance Company: _____		Claim number: _____	
Case Manager: _____		Phone: _____	
Is the patient an existing NDIS participant? ☐ Yes ☐ No ☐ Application pending ☐ Considering			
Pt Location: ☐ Home ☐ Hospital: _____		Ward: _____	Bed: _____ Ward Phone: _____
Referrers Name: _____		Position: _____	Ward: _____
Infectious Status (e.g.MRSA/VRE/ESBL/CRE positive):		Results - ☐ Yes ☐ No (please attach results)	
PATIENT DETAILS			
Diagnosis / HPI / Complications			
Relevant Past Medical History			
Allergies			
Clinical Risks (e.g. Delirium)			
Social Situation			
Proposed d/c destination			
CURRENT MOBILITY STATUS, LEVEL OF DEPENDENCE, ADLS			
Mobility	☐ Indep ☐ s/v ☐ 1 Assist ☐ 2 Assist ☐ Immobile ☐ Walking Aid (Type): _____ Distance: _____ m		
Transfers	☐ Indep ☐ s/v ☐ 1 Assist ☐ 2 Assist ☐ Standing Hoist ☐ Full Hoist		
Weight bearing	☐ FWB ☐ WBAT ☐ Partial WB (____%) ☐ TWB ☐ NWB Date of next WB status review: _____		
Cognition	☐ Alert ☐ Orientated ☐ Confused ☐ Wandering ☐ Non-compliant MOCA / MMSE score (if done): _____		
Falls Risk	☐ At Risk ☐ No risk		No. falls in last 6 months: _____ No. falls during current admission: _____
Continence	Bladder: ☐ Continent ☐ Incontinent ☐ IDC ☐ SPC		Weight _____ kg
	Bowel: ☐ Continent ☐ Incontinent		Toileting ☐ Indep ☐ Supervision ☐ Assistance
Showering	☐ Indep ☐ Supervision ☐ Assistance		Wounds ☐ No ☐ Yes Specify: _____
Diet	Communication		
Fluids	☐ Thin ☐ Slightly Thick ☐ Mildly Thick ☐ Moderately Thick ☐ Extremely Thick ☐ Nil by Mouth		
Medication	☐ Independent ☐ Supervision ☐ Assist required ☐ PICC line ☐ IV AB's		
Previous functional status			
REHABILITATION PLAN & GOALS			
Patient willingness and ability to comply with program? ☐ YES ☐ NO			
Rehab Goals: _____			
ASSESSMENT COMPLETED BY: Name:		Signature:	Date:
ACCEPTED BY VMO: Name:		Signature:	Date:
Please send a copy of: 1) Recent progress and admission notes 2) Medication charts 3) Recent pathology results/scans and 4) ECG + any other information you feel is relevant to the referral.			