Waratah
Private Hospital

REHABILITATION/MEDICAL REFERRAL

FAX 9598 0003 PHONE 9598 0002

AFFIX REFERRING HOSPITAL LABEL

REQUESTED ADMISSION DATE: _____/_____/_____

TO BE COMPLETED BY THE REFERRING HOSPITAL

Further details may be required on preadmission assessment. Our Patient Access Manager will contact you about bed availability and the patient's suitability for our rehabilitation programs.

☐ **REHABILITATION PROGRAM**
☐ **MEDICAL**

1. ADMISSION DETAILS:

Referring hospital admission date:	☐ ED ☐ Ward Name:______________________
Referring specialist:	Previous patient at Waratah Private Hospital: ☐ Yes ☐ No

2. INSURANCE DETAILS:

DVA:	☐ Gold ☐ White	Health Fund: Membership No.:
☐ WC ☐ CTP	Insurance Co.:	Claim No.:

3. NEXT OF KIN:

Next of kin:	Relationship: Phone:
Enduring Guardianship/Power of Attorney (if applicable) - Name:	

4. CLINICAL DETAILS:

Admission Diagnosis: Date of Surgery: ____/____/____

Medical, Surgical and Psychological History:

Current Mental Status: ☐ Alert ☐ Orientated ☐ Confused ☐ Cooperative ☐ Behavioural concerns

Do you require an interpreter: ☐ Yes ☐ No If yes, which language: ______________________

Allergies/Alerts:______________________

Advance Care Plan: ☐ Yes ☐ No

Recent ACAT Assessment: ☐ Yes ☐ No Details: ______________ **Community Services:** ☐ Yes ☐ No

Social situation: ☐ Lives alone ☐ Lives with partner/spouse ☐ Live with relative ☐ Lives with carer
☐ Cultural needs Specify: ______________________

Type of accommodation: ☐ Home/Unit ☐ Retirement Village ☐ Hostel ☐ Nursing Home

Premorbid ADL Status: ☐ Ind ☐ Sup ☐ Assist ☐ Equipment: ______________

Current ADL Status: ☐ Ind ☐ Sup ☐ Assist ☐ Equipment: ______________

Weight Bearing Status: ☐ FWB ☐ WBAT ☐ PWB ☐ TWB ☐ NWB (for ________ more weeks)

Current Mobility Status: ☐ Ind ☐ Sup ☐ Assist ______ Person(s) ☐ Min ☐ Mod ☐ Max ☐ With aids: ______________

Current Transfers: ☐ Ind ☐ Assist ______ Person(s) ☐ Min ☐ Mod ☐ Max ☐ Lifter

Current Continence Status: **Bladder** ☐ Yes ☐ No ☐ IDC ☐ SPC ☐ **O_2 Therapy:** ☐ Yes ☐ No
Bowel ☐ Yes ☐ No ☐ Colostomy ☐ Ileostomy

Nutrition: ______________ ☐ Normal ☐ Special Type: ______________ ☐ NG ☐ PEG

Weight (Kgs): __________ ☐ Supplements: ☐ Yes ☐ No Specify:______________

Wounds: ______________________

Type of dressing & frequency: ______________________

MRSA Screening: ☐ Yes ☐ No **Site:** ______________ **Result:** ______________

☐ **MRO Site:** ______________ **Other** (Please state): ______________

Referring person name:______________ **Designation:**______________

Referring hospital:______________ **Phone number:** ______________

BINDING MARGIN — DO NOT WRITE

REHABILITATION/MEDICAL REFERRAL

MR-R02