HammondCare Champion Life

BRAESIDE HOSPITAL REHABILITATION REFERRAL FORM

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
DOB	M.O
ADDRESS	
LOCATION/ WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Referrer:			Contact Phone:		
Date referred for rehab consult:			Date placed on wait list:		
Financial Status:	☐ Medicare	☐ Private	☐ Other (Specify):		
NB: If patient is covered by CTP, please send insurance acceptance letter for Rehabilitation with referral					
Primary Reason for Admission:					
Treatment/Surgery: Surgery Date:					
Infection Status: ☐ MRSA	☐ VRE	☐ ESBL	☐ Other (specify):		
Complications/Clinical Progress:					
Current active medical issues/management plan:					
Significant Medical History:					
Premorbid Level of Function:					
Accommodation: ☐ Own Home	☐ DoH	☐ RACF			
Mobility:	☐ Independent	☐ Supervision	☐ Assistance	☐x 1	☐x 2
Mobility Aids:	☐ No	☐ Yes	☐ Type:		
ADLs:	☐ Independent	☐ Supervision	☐ Assistance		
Current Level of Function:					
Mobility status:					
Weight Bearing Status: ☐ WBAT	☐ PWB	☐ TWB	☐ NWB		
Self-Care Status:					
Cognition:	☐ Alert	☐ Confused	☐ MMSE/RUDAS:		
Behaviours:	☐ Impulsive	☐ Wanderer	☐ Aggression		
Antibiotics:	☐ No	☐ Yes	☐ Oral	☐ Yes	☐ Oral
Plan:					
Wound/Pressure Injury:	☐ No	☐ Yes	Location:		
IDC/Enteral Tube/Stoma:	☐ No	☐ Yes	Date of insertion:	Plan:	
Bariatric Equipment:	☐ No	☐ Yes	Weight:	Details:	
Referring Team follow-up plan post discharge:					
Patient Rehab Goals:					
NDIS Status (if applicable):					
Referrer Signature:					
☐ Inpatient Referral Email referral to: bsrehabinpatient@hammond.com.au					

BINDING MARGIN NO WRITING

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