In-patient Rehabilitation referral form

Patient Details

Patient's Full Name	**Referring Hospital**
Date of Birth:	Date of Admission:
or affix patient label if available	

Referring Doctor ……………………………………………………………………………………
Name Contact or Provider Number

MRSA Swabs taken	Anticipated date of transfer to St Luke's	Health Fund Name ………………………… Membership No ……..………………………..
☐ Yes …………….. Date ☐ No	…………………………… Room Type Preference: ☐ Shared ☐ Single ☐ Either	Co-payment paid $............... ☐ None paid Excess paid $................ ☐ None paid

Assessment of suitability for admission will generally be required for all patients other than elective hip or knee replacement patients who have no ongoing acute medical problems. St Luke's will arrange this assessment, where required

Diagnosis/ Reason for Referral: including date of surgery if applicable
Mobility status:
Weight bearing: ☐ Full ☐ Partial WB ☐ Touch WB ☐ Non WB ________ Duration ________ Duration ________ Duration
Cognitive state:
How does this patient comprehend and co-operate with therapy instructions ? ☐ Fully ☐ Somewhat ☐ Not very well ☐ Not at all
Please describe any acute medical problems or other conditions affecting current care:
Bladder / bowel continence:
Usual living arrangements: ☐ Own home ☐ alone ☐ with relative/s ☐ Own home with carer support ☐ Hostel

Form completed by: .... ……………………………….
Please Print Name Position

Telephone Number: ……………………………………….. Date: ……………………………..

Fax to St Luke's Booking Office (02) 9356 0431

Telephone enquiries to Nursing Unit Manager, Rehabilitation Unit (02) 9356 0202