ST LUKE'S CARE

# REFERRAL FORM

FAX WITH PATIENT DETAILS FORM TO **(02)9356 0431**

*Attach patient identification label (Hospital Use Only)*

UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

**To be completed by Specialist/GP/Discharge Planner.** Please PRINT clearly.

## PROGRAM

☐ Inpatient rehabilitation ☐ Half-day rehabilitation

## PATIENT DETAILS

Title: Given names: Surname:

Date of birth: / / Gender: ☐ Male ☐ Female

Address:

Telephone (Home): (Mobile):

Health fund name: Membership number:

## ALL PATIENTS – CLINICAL DETAILS

**Requested start date:** / /

Reason for referral (include date of surgery if applicable):

Relevant medical history:

Mobility status: ☐ W/chair ☐ FASF ☐ Rollator ☐ PUF ☐ Crutches ☐ Stick/s ☐ Independent

Weight bearing status: ☐ Full ☐ Partial ☐ Touch ☐ Weight bearing as tolerated
☐ Non weight bearing Length:

Cognitive status: ☐ Intact ☐ Confusion ☐ Delirium ☐ Dementia

Known infection: ☐ Yes ☐ No If yes, details:

Hydrotherapy: ☐ Yes ☐ No Weight: kg

Usual living arrangements: ☐ Own home ☐ Alone ☐ With relatives ☐ Own home with carer support ☐ Hostel

## CURRENT INPATIENTS – CLINICAL DETAILS

Hospital where patient is currently admitted:

Hospital contact person: Contact details:

MRSA swabs taken: ☐ Yes ☐ No Date: / / Falls risk:

Risk of pressure injury: ☐ Yes ☐ No Wound management required: ☐ Yes ☐ No

| | | | | |
|---|---|---|---|---|
| **Mobility status:** | Bed mobility: | ☐ Independent | ☐ Supervision | ☐ Assistance |
| | Sit to stand: | ☐ Independent | ☐ Supervision | ☐ Assistance |
| | Ambulation: | ☐ Independent | ☐ Supervision | ☐ Assistance |
| **Continence status:** | Urine: ☐ IDC | ☐ Continent | ☐ Incontinent | |
| | Faeces: | ☐ Continent | ☐ Incontinent | |
| **Personal care:** | ☐ Independent | ☐ Requires assistance | ☐ Fully dependent | |
| **Discharge destination:** | Type: ☐ Home | ☐ Nursing Home | ☐ Hostel | ☐ Other |
| | Where: ☐ Family | ☐ Friend | ☐ Alone | ☐ Other |

## REFERRER'S DETAILS

Referrer's name: Signature:

Provider number: Date: / /

SPECIALIST / DISCHARGE PLANNER / GP TO COMPLETE

REFERRAL FORM

MR5

LC4703 SLC 17032016

PATIENT TO COMPLETE

ST LUKE'S CARE

# PATIENT DETAILS FORM

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UR No.: Admission No.:

Surname:

Given Names:

Date of Birth: / / Gender:

Doctor:

**To be completed by patient.** Please PRINT clearly.

## PERSONAL DETAILS

Title: Given names: Surname:

Previous surname (if applicable):

Date of birth: / / Gender: ☐ Male ☐ Female

Residential address:

Postal address (if different):

Telephone (Home): (Mobile): (Work):

Email: Language spoken:

## INSURANCE DETAILS

Health fund name: Membership number:

Medicare number: Medicare ID: Expiry date: /

Pension number: DVA number:

DVA card colour: ☐ White ☐ Gold Patient admit as DVA: ☐ Yes ☐ No

Patient claiming Workers Comp: ☐ Yes ☐ No Patient claiming Third Party: ☐ Yes ☐ No

If yes, insurance company: Claim number:

Contact person: Contact number:

Liability accepted: ☐ Yes ☐ No ☐ Unsure Fax number:

## PERSON TO CONTACT (NEXT OF KIN)

Name: Relationship:

Address:

Telephone (Home): (Mobile): (Work):

Second contact: Phone:

## DETAILS OF GP

Name: Phone: Fax:

Address:

## PREVIOUS HOSPITALISATION

Have you previously been treated at St Luke's Hospital?: ☐ Yes ☐ No Year:

Have you been hospitalised for more than 48 hours within the past 3 months?: ☐ Yes ☐ No

Dates: from / / to / / Name of hospital:

Admitting Doctor: Date of operation (if applicable): / /

Admission Type: ☐ Overnight ☐ Day patient ☐ Rehabilitation

## ST LUKE'S OFFICE USE ONLY

MRN: Eligible for rehab: ☐ Yes ☐ No ☐ by fax ☐ by email ☐ by phone

Further information/assessment required: ☐ Yes ☐ No Excess/Co-payment:

Comments:

Confirmed admission date: / / Signature:

PATIENT DETAILS FORM

MR6