



Patient ID Label

1 Emu Street, Strathfield NSW 2135  
 Tel. (02) 9747 5333 **Please fax to: (02) 8745 2250**

**REFERRAL FORM**

**REFERRAL DATE:** / /

In-patient  Single Room requested  Day Program

Room Assigned (Alwyn) \_\_\_\_\_

**Patient's Name** \_\_\_\_\_  Male  Female **DOB** / /

Address \_\_\_\_\_ Country of Birth \_\_\_\_\_

Telephone \_\_\_\_\_ Religion \_\_\_\_\_ NESB  Language spoken \_\_\_\_\_

Next-of-Kin \_\_\_\_\_ Relationship \_\_\_\_\_ Tel. \_\_\_\_\_

NOK Address \_\_\_\_\_

<b>REFERRING HOSPITAL:</b> _____	<b>Ward:</b> _____
<b>Referring Hospital Contact:</b> _____	<b>Telephone</b> _____
<b>Referring Specialist:</b> _____	<b>Telephone</b> _____
<b>Specialist Rooms Address</b> _____	
<b>GP Name:</b> _____	<b>Telephone</b> _____
<b>Address</b> _____	
<b>Expected Date of Admission to Alwyn:</b> / /	Previous Patient at Alwyn <input type="checkbox"/> NO <input type="checkbox"/> YES Alwyn MRN _____

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**Diagnosis/Operation** ..... **Operation Date:** / /

**Relevant History:** .....

..... **Falls Risk:**  Low  Med  High

**Allergies:**  Drug.....  Food.....

**Cognitive Status:**  Alert  Orientated  Cooperative  Confused  Delirium  Dementia

**Mobility/transfers:**  Independent  Assist \_\_\_ Person(s)  Hoist **Mobility Aid? (type)** .....

**Weight bearing status:**  FWB  WBAT  PWB  TWB  NWB (for \_\_\_ more weeks)

**ADLs:**  Independent  Supervision  Min Assist  Mod Assist  Max Assist

**Continence:**  Continent  Incontinent Urine / Faeces  SPC  IDC  Colostomy

**Skin Integrity:**  Intact  Pressure Areas .....  Skin Tear.....  Wound .....

**Type of Dressing & Frequency:** .....

**Nutrition:**  Diet .....  Supplements.....  Diabetic  PEG

**Social Situation:**  At home - (circle) independent / carer / community supports .....  Hostel /N. Home

**HA Infection:**  MRSA  Recent Diarrhoea & vomiting  Other..... (site) ..... Swabs .....

Recent Communicable diseases .....  Flu Symptoms .....

Hx Psychiatric Illness .....  Wgt. .... kgs

**Medical requirements:**  O2 .....  Hb ..... (Date taken) ..... **Expected destination on discharge:** .....

<b>HEALTH FUND</b> _____ Level of Cover _____	Membership No. _____
Medicare No: _____ No _____	<b>WORKCOVER / THIRD PARTY</b>
Expiry Date ___ / ___ DVA No _____	Insurer _____
Pension Number _____	Claim Number _____
Safety Net or Concession No _____	Case Manager _____
	Telephone No. _____