Alwyn Rehabilitation Hospital

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 _____

REFERRING HOSPITAL: _____ _____ **Ward:** _____

Referring Hospital Contact: _____ **Telephone** _____

Referring Specialist: _____ **Telephone** _____

Specialist Rooms Address _____

GP Name: _____ **Telephone** _____

Address _____

Expected Date of Admission to Alwyn: / / | *Previous Patient at Alwyn* ☐ NO ☐ YES | *Alwyn* MRN _____

CLINICAL DETAILS

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 ☐ **R**ecent 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**: .....

HEALTH FUND _____ Level of Cover _____ Membership No._____

Medicare No: _____ No _____

Expiry Date ____ / ____ DVA No _____

Pension Number _____

Safety Net or Concession No _____

WORKCOVER / THIRD PARTY

Insurer _____

Claim Number _____

Case Manager _____

Telephone No. _____