THE SYDNEY PRIVATE HOSPITAL

63 Victoria Street, Ashfield NSW 2131

Telephone: (02) 9716 3778
Fax: (02) 9716 3799 Day Patients
Fax: (02) 9716 3798 Inpatients

Rehabilitation Unit
Inpatient and Day Rehabilitation Services

THE SYDNEY PRIVATE HOSPITAL
63 Victoria Street, Ashfield NSW 2131

Rehabilitation Manager
Mob.: 0418754067
Ph.: (02) 9716 3778 Fax: (02) 9716 3798

PATIENT LABEL

REHABILITATION REFERRAL

MR/6B

BINDING MARGIN – NO WRITING

PROGRAM : ☐ INPATIENT ☐ DAY ONLY REHABILITATION ☐ OUT PATIENT

1. PATIENT DETAILS:

Patient's Name: _____ DOB: _____ Age: _____

Sex: ☐ Male ☐ Female Marital Status: M S W D ☐ Single Room Requested

Address: _____

Telephone: _____ Religion: _____ Country of Birth: _____

Next of Kin: _____ Relationship: _____ Telephone: _____

Medicare No.: _____ Expiry Date: _____ Pension No.: _____

Private Health Fund: _____ Membership No.: _____

Is this injury a result of an accident? ☐ Yes ☐ No If yes, is the claim accepted? ☐ Yes ☐ No

WC/CTP Insurance Co: _____ Claim No: _____

Case Manager: _____ Telephone No.: _____

2. REFERRAL DETAILS:

Expected Date of Admission to TSPH: _____ Previous Patient at TSPH: ☐ Yes ☐ No Year: _____

Date of Referral: _____ Person Referring: _____ Expected Length of Stay: _____

Referring from: a) Home: _____ b) Hospital: _____

Referral Hospital: _____ Ward: _____ Telephone: _____

Referring Specialist: _____ Telephone: _____

Specialist Rooms Address: _____

Date of MRSA Swabs: _____ Results: _____

GP: _____ Tel: _____ Fax: _____

GP Address: _____

Preferred Rehabilitation Specialist: _____

3. CLINICAL DETAILS:

Diagnosis/Operation: _____ Operation Date: _____

Relevant History: _____

_____

Current Medications: _____

_____ Allergies: _____

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3. CLINICAL DETAILS:

Physical and Mental Status:

Cognitive Status:	☐ Alert	☐ Orientated	☐ Co-operative	☐ Confused	☐ Dementia
Mobility:	☐ W/C	☐ FASF	☐ Rollator / PUF	☐ Stick/s	
	☐ Crutches	☐ Independent	☐ Minimum assist	☐ Moderate assist	☐ Supervision
ADL's:	☐ Independent	☐ Supervision	☐ Moderate Assist	☐ Minimal Assist	
	☐ Full Assist	☐ Aids:_____			
Weight Bearing Status:	☐ FWB	☐ WBAT	☐ PWB	☐ TWB	☐ NWB (for.....wk)
Continence:	☐ Continent	☐ Incontinent Urine		☐ Incontinent Faeces	
	☐ SPC	☐ IDC			
Feeding:	☐ Self	☐ Assist	☐ NGT	☐ PEG	
	☐ Diet:_____				
Skin Integrity:	☐ Intact	☐ Wound	☐ Pressure Areas	☐ Uicers	
	☐ Type of Dressing:_____				
Physical:	☐ Weight (Kgs):_____	☐ Hb:_____	☐ Date last taken:_____		
Specialist Equipment:	☐ Yes	☐ No	☐ If yes, equipment:_____		
Social Situation:	☐ Home	☐ Self Care Unit	☐ Hostel	☐ Nursing Home	
Pre-Admission Support:	☐ Self	☐ Live-in Spouse/Carer		☐ Community Service	
	☐ Non Live-in Care				
Medical Requirements:	☐ Oxygen				
Rehabilitation Goals:	1:_____				
	2:_____				
	3:_____				

BINDING MARGIN – NO WRITING

Please Note:
When a patient is transferred to The Sydney Private Hospital, please ensure the following accompanies the patient:

- ☐ Appropriate discharge summaries (medical, nursing, allied health, list of medications, etc).
- ☐ Three days of medications supply.
- ☐ Details of follow-up appointment.
- ☐ Copies of report of relevant investigations (x-rays, pathology).

The Sydney Private Hospital office Use Only:

Telephone Assessment Conducted : ☐ Yes ☐ No Date:_____

Contact:_____ Telephone:_____

Face to Face Assessment Conducted: ☐ Yes ☐ No Date:_____

Patient Agrees to Transfer to The Sydney Private Hospital, if accepted: ☐ Yes ☐ No

Patient aware of, and agrees to, participate in therapy: ☐ Yes ☐ No

Patient informed of costs/health fund excess or co-payment (if applicable) and other charges such as Allied Health/Transport to and from the hospital ☐ Yes ☐ No

Additional information:_____

Assessor:..... Signed: ..... Date: .....