THE SYDNEY PRIVATE HOSPITAL

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PLEASE PRINT CLEARLY

SURNAME		UNIT NUMBER
OTHER NAMES		
ADDRESS		
D.O.B.	SEX	MEDICAL NUMBER
WARD		DOCTOR

PROGRAM TYPE: ☐ INPATIENT ☐ OUTPATIENT

☐ Heart Wellness (Cardiac Rehab) ☐ Orthopaedic ☐ Neurological ☐ Reconditioning OR Other_____

PATIENT DETAILS:

Title:_____ Given names:_____ Surname:_____

Address: _____

Mobile:_____ Phone (H):_____ _____Date of birth: ____/____/____

☐ Male ☐ Female

Person responsible:_____ Relationship:_____ Contact No.:_____

GP name:_____ Contact No:_____

Medicare No.:_____ Ref No.: _____ Expiry date:____/____/_____Pension No.:_____

PBS No.:

Helath Fund/DVA/Insurance name:_____ Membership/DVA No.:_____

Schedule:_____ Excess: $_____ Co-payment: $ _____

Usual living arrangements: ☐ Alone ☐ With partner ☐ With relatives ☐ With carer ☐ Hostel ☐ Nursing Home

ABTSI culture: _____

CLINICAL DETAILS: ***On transfer, please provide copies of medication charts, dopplers, bloods and any scans***

Diagnosis: _____

Recent ACAT Assessment: ☐ No ☐ Yes _____

Details:

Allergies: _____

Anti-coagulants: ☐ No ☐ Yes Medications coming with patient: ☐ No ☐ Yes

Cardiopulmonary Status: _____ Requires O^2: ☐ No ☐ Yes

MRSA swabs: ☐ Nose (+ve / -ve) ☐ Axilla (+ve / -ve) ☐ Groin (+ve / -ve) ☐ Wound (+ve / -ve)

VRE history: ☐ No ☐ Yes MRSA history: ☐ No ☐ Yes

Wound / Pressure injury:_____ Waterlow score: _____

Swallowing intact: ☐ No ☐ Yes ☐ NGT / PEG

Diet: ☐ Normal ☐ Diabetic ☐ Tube feed ☐ Supplement: _____

PHYSICAL STATUS:

Falls Risk: _____ Weight:_____ (kg)

Mobility- Assistance: ☐ Independent ☐ Supervision + A ☐ Assist x 1 ☐ Assist x 2

Aide: ☐ Nil ☐ FASF ☐ 4WW ☐ 2WW ☐ Stick/s ☐ 4WCrutches ☐ Wheelchair

Weight bearing: ☐ N/A ☐ Partial ☐ Touch ☐ WBAT ☐ NWB (weeks): _____

Cognitive: ☐ Intact ☐ Confusion ☐ Delirium ☐ Dementia ☐ Wanderer

Continence- Bladder: ☐ Continent ☐ Incontinent ☐ IDC

Bowel: ☐ Continent ☐ Incontinent ☐ Colostomy

Personal care: ☐ Independent ☐ Requires assistance ☐ Fully dependent

Vision: ☐ Normal ☐ Glasses ☐ Blind: ☐ Partial ☐ Full

DOES THE PATIENT HAVE AN ADVANCE CARE DIRECTIVE: ☐ No ☐ Yes

TRANSFERRING FACILITY DETAILS:

Facility name:_____ Ward: _____ Date admitted:____/____/____

Contact person:_____ Phone: _____ Expected transfer date: ____/____/____

Discharge destination: ☐ Home ☐ Aged Care facility ☐ Transitional care ☐ With: _____

REFERRER'S DETAILS:

BINDING MARGIN – NO WRITING

REFERRAL FORM

MSO 113315 Implemented June 2016 Revised 02/22

MR/6B