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

REFERRAL FORM

PROGRAM TYPE: ☐ INPATIENT ☐ OUTPATIENT

☐ Orthopaedic ☐ Neurological ☐ Reconditioning ☐ 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:

Referrer's name: ____________________ Signature:____________

Provider No:____________________ Date:___/___/___

PATIENT AGREEMENT:

Patient signature:____________________ Date:___/___/___

BINDING MARGIN – NO WRITING

MSO 113315 Implemented June 2016 Revised 02/22

MR/6B