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| **S Southern Adelaide Local Health Network NOTE**- For any queries regarding referrals please contact

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| --- |
| **PATIENT DETAILS** |
| **Surname:****Given Name(s):** | **DOB:** | **Gender:**M [ ]  F[ ]  | **Phone:****Mobile:** |
| **Address:** | **Medicare no:** |   **MRN:** |
| **GP Details** Name: Contact No:  |
| **Postal address (if different to above):** | **Interpreter/Language:****Y** [ ]  N [ ]  If yes details: ……………………….. |
| **Patient Consent to referral Yes** [ ]   **No** [ ]  | **Aboriginal** [ ]  **Both** [ ]  **Torres Strait Islander** [ ]  **Neither** [ ]   |
| **SUBSTITUTE DECISION MAKER/PERSON RESPONSIBLE (IF APPLICABLE)** |
| **Name: Relationship: Contact No:** |
| **SOCIAL STATUS** |
| **Usual accommodation:** [ ]  Home [ ]  Unit [ ]  Other Comment:**Lives with:** [ ]  Spouse [ ]  Alone [ ]  Other Comment: |
| **Support Services received in Community:**  |

**Day Rehabilitation Services Referral Day Rehabilitation Service Manager** Contact Ph:**(08)** 8404 2269

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| --- |
| **REFERRAL DETAILS** |
|  **Hospital** (if applicable): |  **Ward/Location:** |  **Acute Admission Date:** **Date of Surgery:** (if applicable) |
|  **Diagnosis/Condition Requiring Rehabilitation:** |
|  **Past Medical History:** |  **Allergies**: |
|  **Advanced Care Directive:** Yes No Details: **Resuscitation Plan:** Yes No Details: |
|  **Infection Precautions/Concerns (include MRO status)** Yes No Details: |
|  **Current Behavioural/Cognitive Concerns**:  |
|  **Current Medication (attach list if insufficient space):**  |
|  **FUNCTIONAL STATUS (Comment on mobility, personal care, transfers, continence, communication and equipment required)** |
|  |
|  **REHABILITATION GOALS-** **PLEASE INDICATE 3 OR 4 GOALS** |
|  |
|  **REFERRER’S DETAILS** |
|  Name: Designation: Signature:  |
|  Phone/Pager:  |  Provider# (if applicable):  |  Date: |

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 **PLEASE FAX REFERRAL FORM TO 8404 2263 Email:** **Health.SALHNDayRehabService@sa.gov.au**