PATIENT DETAILS

DATE OF REFERRAL:

Surname: **Given Name(s):**	**DOB:**	**Gender:** M ◯ F ◯	**Phone:** **Mobile:**
Address:	**Medicare No:**		**MRN:**
	GP Details-Name:		**Contact No:**

◯ **Aboriginal** ◯ **Torres Strait Islander** ◯ **Both** ◯ **Neither** **Interpreter/Language: Yes** ◯ **No** ◯ If yes details-

SUBSTITUTE DECISION MAKER/PERSON RESPONSIBLE/NEXT OF KIN DETAILS (IF APPLICABLE)

Name:	**Relationship:**	**Contact No:**
Patient Consent to referral: Yes ◯ **No** ◯	**NOK aware of referral: Yes** ◯ **No** ◯	

REFERRER DETAILS

Name:	**Signature:**	**Designation:**
Provider No. (if applicable):	**Contact Details-Phone/Pager # :**	

Have you or a member of your household returned from overseas or interstate travel in the last 14 days?	**Yes** ◯ **No** ◯
Have you or a member of your household been advised that you should be in home isolation for coronavirus?	**Yes** ◯ **No** ◯
Have you or a member of your household been advised you are a close contact risk with a confirmed or suspected case of coronavirus?	**Yes** ◯ **No** ◯
Is anyone in your household or those you are in close contact with experiencing and symptoms of cough, sore throat, fever, shortness of breath?	**Yes** ◯ **No** ◯

DETAILS OF REFERRAL

REFERRAL STREAM	
◯ **Inpatient Rehabilitation**	Rehab DECT phone 67849 Fax number: (08) 8404 2292 Email:Health.SALHNDivRAPTriage@sa.gov.au
◯ **Home Rehabilitation*** *please complete additional information at bottom of this form	All referrals need to be discussed and approved by the Home Rehabilitation Manager Phone: 0478 404 030 Fax number: (08) 8404 2292 Email: homerehab@sa.gov.au
Referring Hospital:	**Ward/Location:**
Admission Diagnosis:	**Date of Admission:** **Expected date of discharge:**

History of Presenting Complaint:

Past Medical History:	**Weight:** **Allergies:** **Wounds:** Yes ◯ No ◯ **Describe:**
INR/Warfarin: Yes ◯ No ◯ **Details:**	**Location:** **Wound Chart Attached:** Yes ◯ No ◯

Social History (home environment i.e. steps/access issues, family or informal supports):

Usual Accommodation:

Home Environment:

Lives With:

Family or formal supports prior to presentation:

Social Issues that may impact discharge:

Advanced Care Directive: Yes ◯ No ◯ **Detail:**

Clearly indicated Resuscitation Status: Yes ◯ No ◯ **Detail:**

Infection Precautions/Concerns (include MRO status): Yes ◯ No ◯ **Detail:**

Cognitive Concerns: Yes ◯ No ◯ **Detail:**	**MMSE:**	**MOCA:**

Behavioural Issues:

Summary of Current Medical Issues/Concerns (include if on O2, diabetic):

Current Medication (attach list if insufficient space):

CURRENT LEVEL OF FUNCTION

Name: **MRN:** **Date:**

ADLS:

Current	*Pre-morbid*
◯ independent ◯ standby assist ◯ 1x assist ◯ 2x assist ◯ Dependent Aid: Comment:	◯ independent ◯ assistance required Specify: Comment:

TRANSFERS:

Current	*Pre-morbid*
◯ independent ◯ standby assist ◯ 1x assist ◯ 2x assist ◯ Dependent Aid: Comment:	◯ independent ◯ assistance required Specify: Comment:

MOBILITY:

Current	*Pre-morbid*
◯ independent ◯ standby assist ◯ 1x assist ◯ 2x assist ◯ Dependent Aid: Comment:	◯ independent ◯ assistance required Specify: Comment:

COMMUNICATION:

◯ Normal ◯ Dysphasia ◯ Dysarthria ◯ Dyspraxia **Comment:**

CONTINENCE:

Urinary: ◯ continent ◯ incontinent ☐ aids **Comment:**

Faecal: ◯ continent ◯ incontinent ☐ aids **Comment:**

MODIFIED DIET:

Yes ◯ No ◯ **If yes, specify (food & fluid):**

REHABILITATION GOALS- PLEASE INDICATE 3 OR 4 GOALS - Including nursing goals as appropriate

ADDITIONAL INFORMATION REQUIRED FOR HOME REHABILITATION REFERRAL

Consent to Visit: Yes ◯ No ◯

Discharge location: (own home, staying with family, RCF)

Does client require Medication Management (including IVABx):
Yes ◯ No ◯ **Detail:**
Is assistance required with medications? Yes ◯ No ◯ ***If yes, 'Medication Authority' required (Send with d/c summary)***

Off-Site Risk Assessment
*Information provided to best of referrer's knowledge and reliant on details provided by client / family**

Known ETOH / Drugs / Aggression history: Yes ◯ No ◯ Detail:

Smoker: Yes ◯ No ◯ | Weapons: Yes ◯ No ◯

Pets: Yes ◯ No ◯ Detail:

OVERALL RISK: High ◯ Medium ◯ Low ◯

DISCHARGE SUMMARY FOR PATIENTS TRANSFERRING TO HOME REHABILITATION TO ALSO INCLUDE (AS RELEVANT/ REQUIRED)

- **UP TO DATE MEDICATION LIST**
- **1 WEEK HISTORY OF INR MONITORING/WARFARIN DOSING HISTORY**
- **WOUND CHART**

PLEASE ENSURE THAT A COMPLETED DISCHARGE SUMMARY IS SENT TO THE RELEVANT SERVICE ON DAY OF TRANSFER