



RHC101670

BINDING MARGIN - DO NOT WRITE

 Ramsay Health Care	Rehabilitation Unit Pre-Admission & Referral Form	Surname: _____	
Rehab Unit Name/Contact/Fax No/Email: Cairns Private Hospital Inpt Phone: (07) 4052 5269 / Daypt Phone: (07) 4052 8059 Fax: (07) 4052 5372 Inpt email: RehabReferrals.CPH@ramsayhealth.com.au Daypt email: dayrehab.cph@ramsayhealth.com.au		Given Name: _____	
		Address: _____	
		DOB: _____	Sex: _____
(Affix Patient Identification label here, if available)			
REFERRAL DETAILS		Referring Dr:	
Referral to: (Optional)		Signature:	
☐ INPATIENT REFERRAL (assessed as requiring 24 hour nursing care)		Ph:	
☐ DAY PROGRAM REFERRAL (full day / half day)		Provider No:	
Referral Date:	Requested admission date:	Patient Ph:	
Person for notification: Address:	Ph:	Relationship:	
Usual GP:	Medicare No.:	Exp:	
Patient Health Fund:	Health fund No.:	DVA No.:	
☐ Workers Comp ☐ Third Party: If yes: Insurance Company:		Claim number:	
Case Manager:		Phone:	
Is the patient an existing NDIS participant? ☐ Yes ☐ No ☐ Application pending ☐ Considering			
Pt Location: ☐ Home ☐ Hospital:	Ward:	Bed:	Ward Phone:
Referrers Name:	Position:	Ward:	
Infectious Status (e.g.MRSA/VRE/ESBL/CRE positive):		Results - ☐ Yes ☐ No (please attach results)	
PATIENT DETAILS			
Diagnosis / HPI / Complications			
Relevant Past Medical History			
Allergies			
Clinical Risks (e.g. Delirium)			
Social Situation			
Proposed D/C destination			
CURRENT MOBILITY STATUS, LEVEL OF DEPENDENCE, ADLS			
Mobility	☐ Indep ☐ S/V ☐ 1 Assist ☐ 2 Assist ☐ Immobile ☐ Walking Aid (Type): _____ Distance: _____ m		
Transfers	☐ Indep ☐ S/V ☐ 1 Assist ☐ 2 Assist ☐ Standing Hoist ☐ Full Hoist		
Weight bearing	☐ FWB ☐ WBAT ☐ Partial WB (____ %) ☐ TWB ☐ NWB Date of next WB status review:		
Cognition	☐ Alert ☐ Orientated ☐ Confused ☐ Wandering ☐ Non-compliant MOCA / MMSE score (if done):		
Falls Risk	☐ At Risk ☐ No risk	No. falls in last 6 months:	No. falls during current admission:
Continence	Bladder: ☐ Continent ☐ Incontinent ☐ IDC ☐ SPC	Weight	_____ kg
	Bowel: ☐ Continent ☐ Incontinent	Toileting	☐ Indep ☐ Supervision ☐ Assistance
Showering	☐ Indep ☐ Supervision ☐ Assistance	Wounds	☐ No ☐ Yes Specify:
Diet	Communication		
Fluids	☐ Thin ☐ Slightly Thick ☐ Mildly Thick ☐ Moderately Thick ☐ Extremely Thick ☐ Nil by Mouth		
Medication	☐ Independent ☐ Supervision ☐ Assist required ☐ PICC line ☐ IV AB's		
Previous functional status			
REHABILITATION PLAN & GOALS			
Patient willingness and ability to comply with program? ☐ YES ☐ NO			
Rehab Goals:			
ASSESSMENT COMPLETED BY: Name:		Signature:	Date:
ACCEPTED BY VMO: Name:		Signature:	Date:
Please send a copy of: 1) Recent Progress and admission notes 2) Medication charts 3) Physiotherapist notes 4) Occupational therapist notes 5) Social Worker/ Discharge Planner notes			