Minchinbury Community Hospital

MINCHINBURY COMMUNITY HOSPITAL

REHABILITATION / MEDICAL REFERRAL & PRE-ADMISSION FORM

PHONE: 9625 2222

FAX REFERRALS TO 9675 9704 OR EMAIL TO MCHadmin@machealth.com.au

AFFIX PATIENT LABEL HERE

BINDING MARGIN – DO NOT WRITE HERE

RECOMMENDATION FOR ADMISSION FORM

NR 0052/7

REFERRAL DETAILS

DATE OF REFERRAL: _____ EXPECTED ADMISSION DATE: _____ REFERRING DOCTOR: _____

REFERRING FROM: ☐ Home ☐ Hospital DATE OF HOSPITAL ADMISSION: _____ Ward: _____

REFERRING HOSPITAL: _____ Phone: _____ Fax: _____

Was patient transferred from another hospital: ☐ Yes ☐ No Previous Hospital: _____ Date of Admission: ___/___/___

GP: _____ Phone: _____

PATIENT DETAILS

NAME: _____ TITLE: _____ MARITAL STATUS: ○ M ○ S ○ W ○ D

LANGUAGE/S SPOKEN AT HOME: _____ DOB: _____ AGE: _____ SEX: ○ M ○ F

ADDRESS: _____

COUNTRY OF BIRTH: _____ RELIGION: _____ OCCUPATION: _____

PHONE (Home): _____ PHONE (Work): _____ MOBILE: _____

NEXT OF KIN: _____ RELATIONSHIP _____ PHONE: _____

ARE YOU OF ABORIGINAL / TORRES STRAIT ISLANDER (TSI) DESCENT? ☐ No ☐ ABORIGINAL ☐ TSI ☐ BOTH ABORIGINAL & TSI

MEDICARE / PENSION / INSURANCE DETAILS

Medicare No: _____ Expiry Date: ___/___ ID No.: _____ Pension No.: _____

Private Health Fund: _____ Membership No.: _____

DVA No.: _____ Type of DVA Card: _____

Is the patient claiming Workers Compensation: ☐ Yes ☐ No Is the patient claiming Third Party: ☐ Yes ☐ No

Insurance Co.: _____ Claim No: _____ Contact No: _____

CLINICAL DETAILS

Presenting Diagnosis for Acute Admission: _____

_____ Date of Op/Accident: ___/___/___

Diagnosis/Procedure in Acute Admission: _____

Reason for Rehab Admission: _____

Medical History: _____

_____ Allergies: _____

Current Medication: _____

Recent ACAT Assessment ☐ Yes ☐ No Details: _____

Medical Requirements Weight _____ kgs ☐ Diabetic ☐ ECG ☐ O^2 ☐ IV ☐ CVC ☐ PICC

Physical Requirements Is specialized hospital equipment required: ☐ No ☐ Yes Type _____

Social History ☐ Lives Alone ☐ Lives with Partner ☐ Lives with Carer ☐ Lives with Relative

Type of Accommodation ☐ Home/Unit ☐ Retirement Home ☐ Low Level Care ☐ High Level Care

Premorbid ADL Status ☐ Independent ☐ Supervision ☐ Assistance - Min / Mod / Full (please circle)

Community Services ☐ SHN ☐ MOW ☐ Home Care ☐ Other: _____

Current Mental Status ☐ Alert ☐ Orientated ☐ Co-Operative ☐ Confused ☐ Dementia

Current Mobility Status ☐ Independent ☐ Supervision ☐ Assist ☐ With Aids: _____

Current Transfers ☐ Independent ☐ Supervision ☐ Assist

Current Self Care Status ☐ Independent ☐ Supervision ☐ Assistance - Min / Mod / Full (please circle)

Current Continence Status BLADDER ☐ Continent ☐ Incontinent ☐ IDC / SPC

BOWEL ☐ Continent ☐ Incontinent ☐ Colostomy

Weight Bearing Status ☐ FWB ☐ WBAT ☐ PWB / TWB ☐ NWB for _____ more weeks

Skin Integrity ☐ Intact ☐ Wound/s ☐ Pressure Area/s

AREA/S, TYPE OF DRESSING & FREQUENCY: _____

Swallowing Intact ☐ Yes ☐ No ☐ NGT / PEG

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

☐ Vegetarian ☐ Vegan ☐ Gluten Free

MRSA Status ☐ Yes ☐ No SWABS ATTENDED: _____ Date Attended: ___/___/___

PLEASE SEND PATIENT WITH THREE (3) DAYS SUPPLY OF MEDICATIONS + COPY OF MEDICATION CHART & PHYSIO REPORT

NAME: _____ DESIGNATION: _____ Date : ___/___/___