Minchinbury Community Hospital

MACQUARIE HEALTH CORPORATION

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME

GIVEN NAMES

D.O.B. SEX

WARD DOCTOR

UNIT NUMBER

REFERRAL/REHABILITATION & MEDICAL PRE-ADMISSION FORM

PHONE: 02 9625 2222 FAX REFERRALS TO: 9675 9704 OR EMAIL TO: mchadmin@machealth.com.au

PROGRAMME TYPE: INPATIENT OUTPATIENT

Program Type: Heart Wellness (Cardiac Rehab) | Orthopaedic | Reconditioning | Falls Prevention | Neurological | Pain Management | Respiratory | Other

REFERRAL DETAILS

Date of referral: | Expected admision 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:

Language/s spoken at home: | DOB: | Age: | Sex:

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:

Mediacal History:

Allergies:

Current Medication:

Recent ACAT Assessment: Yes No Details:

Medical requirements: Weight: kgs | Diabetic | ECG | O2 | IV | CVC | PICC

Physical requirements: Is specialised hospital equipment required: Yes No | 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

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

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:

BINDING MARGIN – DO NOT WRITE

REFERRAL/REHABILITATION & MEDICAL PRE-ADMISSION FORM MR 4A

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