HOLROYD PRIVATE HOSPITAL
MACQUARIE HEALTH CORPORATION

REFERRAL/REHABILITATION & MEDICAL PRE-ADMISSION FORM

PLEASE USE GUMMED LABEL IF AVAILABLE						
SURNAME						
GIVEN NAMES						
	SEX					
DOCTOR						

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

Date:

Designation:

PHONE: 02 9681 2222 FAX REFERRALS TO: 9632 8480 OR EMAIL TO: holroyd.info@machealth.com.au								
PROGRAMME TYPE: INPATIENT OUTPATIENT								
Program Type Heart \	Wellness (Cardiac Reh	nab) Orthopaedic	Reconditio	ning	Falls Preventi	ion Neurological		
Pain M	Management	Respiratory	Other					
REFERRAL DETAILS								
Date of referral: /	/ Ex	pected admision date:	/ / R	eferring docto	r:			
Referring from: Home	Hospital	Date of hospital a		/	Ward:			
Referring hospital:	<u> </u>	,	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:		Oc	cupation:			
Phone - Home:		Phone - Work:		Mobile:				
Next of kin:		Relationship:		Pho	one:			
Are you of Aboriginal/Torres S	Strait Islander (TSI) De	scent? No Aborigin	nal TSI Both	Aboriginal & T	SI			
MEDICARE / PENSION	/ INSURANCE DE	ETAILS						
				orobin No	Pension No.:			
Private Health Fund: DVA No.:				pership No.: of DVA Card:				
ls the patient claiming Worke	ers Compensation:	Yes No		_	ent claiming Third Part	y: Yes No		
Insurance Co.:		Cla	aim No.:		Contact No.:			
CLINICAL DETAILS								
Presenting Diagnosis for Acu	te Admission:							
Diagnosia/Presedure to A 1	a Adminsiss:					Date of Op/Accident:/		
•								
			Allergi	es:				
Current Medication:								
Recent ACAT Assessment:	Yes No	Details:						
•	Weight:kgs	Diabetic	ECG 02	I	V CVC	PICC		
Physical requirements:	Is specialised hospital		Yes No		Type:	of the section of the		
Social history: Type of accommodation:	Lives alone Home/Unit	Lives with partner Retirement Home	=	s with carer Level Care	=	vith relative evel Care		
Premorbid ADL status:	Independent	Supervision		stance - M				
Community Services:	SHN	MOW	Hon	ne Care	Other:			
Current mental status:	Alert	Orientated		operative	Confus			
Current mobility status:	Independent	Supervision	Ass		With a	ids:		
Current transfers: Current self care status:	Independent Independent	Supervision	☐ Ass		in Mod Deull			
Current sen care status: Current continence status:	Independent BLADDER	Supervision Continent		ontinent	in Mod Full	PC		
oarront continence status.	BOWEL	Continent		ontinent	Colost			
Weight bearing status:	FWB	WBAT		B/TWB	NWB	· ·		
Skin integrity:	Intact	Wound/s		ssure Area/s				
Area/s, type of dressing & frequency:								
Swallowing intact:	Yes No	NGT/PEG	_					
Diet:	Normal	Diabetic		e Fed	Supple	ement:		
MPSA etatuo	Vegetarian No.	Vegan	Glu	ten Free		Data attanded: / /		
MRSA status: PI FASE SEI	Yes No	Swabs attended:	V OF MEDICATIONS	. CORV O	E MEDICATION C	Date attended://		

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