



Minchinbury Community Hospital

MACQUARIE HEALTH CORPORATION

REFERRAL/REHABILITATION & MEDICAL PRE-ADMISSION FORM

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME

GIVEN NAMES

D.O.B.

SEX

WARD

DOCTOR

UNIT NUMBER

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 admission date: / /	Referring doctor:
Referring from: <input type="checkbox"/> Home <input type="checkbox"/> Hospital	Date of hospital admission: / /	Ward:
Referring hospital:	Phone:	Fax:
Was patient transferred from another hospital: <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Aboriginal <input type="checkbox"/> TSI <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient claiming Third Party: <input type="checkbox"/> Yes <input type="checkbox"/> 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: ____/____/____
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BINDING MARGIN – DO NOT WRITE

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