|  |  |  |  |
| --- | --- | --- | --- |
| MRN |  | VMO |  |
|  Surname |  |
| Given Names |  |
| Address |  |
|  | Ph: |  |
| Gender |  | Age |  | DOB |  |
|   | *(Please enter information or affix patient label)* |

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**The Melbourne Eastern Private Hospital**

Ph. (03) 9720-3388 Fax: (03) 9720-5047

|  |  |  |  |
| --- | --- | --- | --- |
| **PROGRAM:** | [ ]  **MEDICAL** | [ ]  **INPATIENT REHABILITATION** | [ ]  **HEART WELLNESS** |
|  | [ ]  **OUTPATIENT** | [ ]  **DAY ONLY REHABILITATION** |  |

1. PATIENT DETAILS:

|  |  |
| --- | --- |
| Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sex: [ ] Male [ ] Female | Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Next of Kin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medicare No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DVA No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Pension No + Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Private Health Fund:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Membership No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ambulance Membership No: [ ] Yes [ ] No WC/TAC Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Claim No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Case Manager Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**REFERRAL FORM**

BINDING MARGIN – DO NOT WRITE

1. REFERRAL DETAILS:

|  |  |
| --- | --- |
| Expected Date of Admission to TMEPH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Person Referring: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Expected Length of Stay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Referring from: [ ]  Home | Referring GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| GP Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Referring Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_ | Ward: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Original Date of Admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Prev Hospital if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Referring Specialist & Provider No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Specialist Rooms Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Multi Resist Organism Status: [ ]  Yes  | [ ]  No | [ ]  MRSA | [ ]  VRE | [ ]  ESBL |
|  [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Swabs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has the ward had any gastro / flu in the past 4 days: [ ]  Yes [ ]  No | Patient affected: [ ]  Yes [ ]  No |
| COVID SWAB: [ ]  Yes [ ]  NoPreferred Doctor/Rehab Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. CLINICAL DETAILS:

**FADM 009**

**MR**

|  |  |
| --- | --- |
| Diagnosis/Operation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Operation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Relevant History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cognitive Status: | [ ]  Alert | [ ]  Orientated | [ ]  Co-operative | [ ]  Confused |
|  | [ ]  Dementia | [ ]  Absconding Risk | [ ]  Aggression |
| Medical Requirements: | [ ]  O2 | [ ]  IV | [ ]  CVC | [ ]  PICC |
| Transfers: | [ ]  Hoist | [ ]  Assist \_\_\_\_\_\_ person(s) | [ ]  Supervision | [ ]  Independent |
| Mobility: | [ ]  Immobile | [ ]  Wheelchair | [ ]  FASF | [ ]  4WW / LRF |
|  | [ ]  2WW / PUF | [ ]  Stick / Crutches | [ ]  No Aids | [ ]  Independent |
| Weight Bearing Status: | [ ]  FWB | [ ]  WBAT | [ ]  Protected WBAT |
|  | [ ]  PWB: \_\_\_\_\_\_\_\_\_\_\_ % | [ ]  TWB | [ ]  NWB (for \_\_\_\_\_ wks) |

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**The Melbourne Eastern Private Hospital**

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| --- | --- | --- | --- |
| MRN |  | VMO |  |
|  Surname |  |
| Given Names |  |
| Address |  |
|  | Ph: |  |
| Gender |  | Age |  | DOB |  |
|   | *(Please enter information or affix patient label)* |

Admissions Manager

Ph. (03) 9720-3388 Fax: (03) 9720-5047

1. CLINICAL DETAILS (CONT’D):

BINDING MARGIN – DO NOT WRITE

**REFERRAL FORM**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ADL’s: | [ ]  Independent | [ ]  Supervision | [ ]  Moderate Assist | [ ]  Minimal Assist |
|  | [ ]  Full Assist | [ ]  Aids: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Continence: | [ ]  Continent | [ ]  Incontinent Urine | [ ]  Incontinent Faeces |
|  | [ ]  SPC | [ ]  IDC | [ ]  Colostomy |
| Feeding: | [ ]  Self | [ ]  Assist | [ ]  NGT | [ ]  PEG  |
| Nutrition: | [ ]  Diabetic | [ ]  Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | [ ]  Diet: *(Fluid restrictions, FODMAP)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Skin Integrity: | [ ]  Intact | [ ]  Wound | [ ]  Pressure Areas | [ ]  Ulcers |
|  | [ ]  Type of Dressing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Physical:  | [ ]  Weight (kgs): \_\_\_\_\_\_\_\_\_\_\_\_ | Hb: \_\_\_\_\_\_\_\_\_ | Date last taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Specialist Equipment: | [ ]  Yes | [ ]  No | If yes, equipment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Social Situation: | [ ]  Home | [ ]  Self-Care Unit | [ ]  Hostel | [ ]  Nursing Home |
| Pre-Admission Support: | [ ]  Self | [ ]  Live in Spouse/Carer | [ ]  Community Service |
|  | [ ]  Non Live in Care |  |  |
| Rehabilitation Goals: | 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Please Note:** |
| When a patient is transferred to The Melbourne Eastern Private Hospital, please ensure the following accompanies  |
| the patient: |
| [ ]  Appropriate discharge summaries (medical, nursing, allied health, list of medications, etc). |
| [ ]  Three days of Medication supply |
| [ ]  Details of follow up appointment(s) |
| [ ]  Copies of report of relevant investigations (x-rays, pathology). |

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| Heart Wellness Patient Referrals **MUST** include: |
| [ ]  Most Recent Letter from the Cardiologist |
| [ ]  Most recent Echocardiogram result |
| [ ]  Most recent Stress Echocardiogram result if available |

**FADM 009**

|  |
| --- |
| The Melbourne Eastern Private Hospital Office Use Only: |
| Telephone Assessment Conducted:  | [ ]  Yes | [ ]  No | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Face to Face Assessment Conducted: | [ ]  Yes | [ ]  No | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient agrees to transfer to TMEPH if accepted: | [ ]  Yes | [ ]  No |
| Patient aware of, and agrees to participate in, therapy: | [ ]  Yes | [ ]  No |
| Patient informed of costs/health fund excess or co-payment (if applicable) and other charges such as Allied |
| Health / transport to and from hospital: | [ ]  Yes | [ ]  No |
| Additional Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| Assessor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |