|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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  No  Preferred 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**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |