THE MELBOURNE EASTERN PRIVATE HOSPITAL
Independent Private Hospitals of Australia

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

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 Claim No: _____
WC/TAC Insurance Co: _____
Case Manager: _____ Telephone: _____
Case Manager Email: _____

2. 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: _____

3. CLINICAL DETAILS:

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)

BINDING MARGIN – DO NOT WRITE

The Melbourne Eastern Private Hospital
REFERRAL FORM
FADM 009

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MRN		VMO	
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Admissions Manager
Ph. (03) 9720-3388 Fax: (03) 9720-5047

3. CLINICAL DETAILS (CONT'D):

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: _____
_____

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).

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

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: _____

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