Robina
Private Hospital

INPATIENT REHABILITATION TELEPHONE / FAX REFERRAL

(Affix identification label here)

URN:

Family Name:

Given Name (s):

Address:

Date of Birth: Sex: ☐ M ☐ F

FAX_____ **PHONE**_____
ALLERGY/ADVERSE DRUG REACTION_____

TO BE COMPLETED BY THE REFERRING HOSPITAL. FAX COMPLETED FORM TO FAX NO. – (07) 5665 5199
Futher details may be required on preadmission assessment. Bed manager will contact you about bed availability if the patient's suitability meets our rehabilitation criteria

1. PATIENT/INSURANCE DETAILS

Address:			Postcode:
Phone (Home):		Mobile:	
Next of kin:		Relationship:	Phone:
Referring person:		Hospital:	Ward:
Referring hospital admission date:		Phone:	Fax:
Referring specialist:	Provider No:		Previous patient at Robina Private: ☐ Yes ☐ N
GP:	Address:		Phone:
DVA:	☐ Gold ☐ White	Health Fund:	Membership No:
☐ WC ☐ CTP	Insurance Co.:		Claim No:
Case Manager:	Phone:	Fax:	Email:

2. CLINICAL DETAILS

Diagnosis:

Date of surgery:

Past Medical History:

Discharge medication list attached: ☐ Yes ☐ No

Recent ACAT Assessment: ☐ Yes ☐ No Details:_____

Social history:	☐ Lives alone	☐ Lives with partner/spouse	☐ Lives with relative	☐ Lives with carer
Type of accommodation:	☐ Home/Unit	☐ Retirement Village	☐ Hostel	☐ Nursing Home
Premorbid ADL status:	☐ Ind	☐ Assist		
Mobility:	☐ Ind	☐ Assist	☐ With aids:	
Current Mental Status:	☐ Alert	☐ Orientated	☐ Confused	☐ Known wanderer
Current Mobility Status:	☐ Ind ☐ Sup	☐ Assist_____ Person(s) ☐ Min ☐ Mod ☐ Max ☐ With aids:		
Current Transfers:	☐ Ind	☐ Assist_____ Person(s) ☐ Min ☐ Mod ☐ Max ☐ Lifter		
Current Self Care Status:	☐ Ind	☐ Sup	☐ Assist	
Current Continence Status:	Bladder Cont.	☐ Yes ☐ No ☐ IDC ☐ SPC		
	Bowel Cont.	☐ Yes ☐ No ☐ Colostomy ☐ Ileostomy		
Weight Bearing Status:	☐ FWB ☐ WBAT ☐ PWB ☐ TWB ☐ NWB (for_____more weeks)			

Wounds:_____ **Type of dressing & frequency**:_____

MRSA Screening: ☐ Yes ☐ No Site:_____ **Result:**_____

☐ **VRE Site:**_____ **Other** (please state):_____

Diet:_____ ☐ Normal ☐ Special ☐ Type:_____ ☐ NG ☐ PEG

Weight (kgs):_____ **Bariatric equipment required**: ☐ Yes ☐ No

O_2 Therapy: ☐ Yes ☐ No **Requested admission date**:_____

ROBINA OFFICE USE ONLY

Ward/ Room:_____ Confirmed admission date:_____

Clinical Program Type:_____ Specialist:_____

Health Fund financial status: ☐ Yes ☐ No Details:_____ By:_____