Robina
Private Hospital

HANDOVER & REFERRAL

Fax this form to: 07 5665 5199
Or Email to Admissionsrobina@healthecare.com.au

(Affix identification label here)

Family Name:
Given Name (s):
Date of Birth:
Current Hospital UR Number:
Age: Sex: ☐ M ☐ F Room No

Address: Suburb:
Email: Mobile:
GP Name: GP Clinic:
GP Phone No:
Select Fund: ☐ Workcover ☐ DVA ☐ NIIS ☐ Private ☐ Self-Funded

DVA Member No: **Pension Card No:**

Medicare Card:
Card No:
Ref No:
Expiry Date:

Workcover/NIIS Nubmer:
Case Manager:
Case Manager Contact Number:

Private Health Fund: Health Fund: Member No:

Referrer Details:
Referring Facility: Ward: Bed:
Contact Person: Contact No:
Treating Specialist:

Acute Admission Diagnosis:

Clinical Assessment

English Proficiency ☐ Good ☐ Moderate ☐ Poor
Interpreter required ☐ Yes ☐ No ☐ Preferred Language:
Hearing ☐ Good ☐ Moderate ☐ Poor ☐ Deaf
Vision ☐ Good ☐ Moderate ☐ Poor ☐ Legally Blind

Next of Kin/Emergency Contact Name: Phone No:

Past Medical History:

Current Medical/Surgical History:

ACAT/ACAS Completed? ☐ Yes ☐ No Date:
Advanced Care Directive? ☐ Yes ☐ No Details:
Enduring Guardianship/EPOA? ☐ Yes ☐ No Details:
Oncology Patient? ☐ Yes ☐ No Diagnosis:
Precautions? ☐ Yes ☐ No Nature & duration:

Next Chemo/Radio cycle – Date (s): Next Oncologist Appointment Date:

Investigations:
1.
2.
3.

MRSA Screening: ☐ Yes ☐ No Site: Result
Other known infections (specify):
Physical State: ☐ Wounds ☐ Lines ☐ Attachments Details
Wound details
Includes dressing ☐ Yes ☐ No Last change date:
Allergies/Alerts (Specify)
Mobility ☐ Ind ☐ Sup ☐ Assist/ ☐ Min ☐ Mod ☐ Max / ☐ With aids
How many people to assist? ☐ 1 ☐ 2 ☐ 3 Specify Aids:
Distance ☐ < 5m ☐ < 5 -20m ☐ < 20-50m ☐ > 50 m
Weight Bearing Status
Showering/Dressing: ☐ Ind ☐ Sup ☐ Assist/ ☐ Min ☐ Mod ☐ Max / ☐ With aids
How many people to assist? ☐ 1 ☐ 2 ☐ 3 Specify Aids:

PTO >>>> SEND BOTH SIDES

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Family Name:
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Date of Birth:
Current Hospital UR Number:
Age: Sex: M F Room No

Toileting: Ind Sup Assist/ Min Mod Max / With aids
How many people to assist? 1 2 3 Specify Aids:

Continent – Bladder Yes No / IDC SPC Incontinence Aids
Continent – Bowel Yes No / Colostomy Ileostomy Incontinence Aids

Mental State Alert Oriented Confused Known Wanderer
Depression Anxiety Dementia Acute Delirium
Additional details

Diet Normal Special Details
NG PEG Jejunostomy

Weight Kgs Bariatric equipment required Yes No Specify

Falls Risk High Moderate Low No of falls in last 12 months

Pressure Injury Yes No

Premorbid Hospital acquired Location

Additional Clinical Details

Pre Morbid State

Mobility Ind Sup Assist/ Min Mod Max / With aids
How many people to assist? 1 2 3 Specify Aids:
Distance < 5m < 5 -20m < 20-50m > 50 m
Weight Bearing Status
Transfers Ind Assist/ Min Mod Max / Lifter
How many people to assist? 1 2 3
Showering/Dressing: Ind Sup Assist/ Min Mod Max / With aids
How many people are required to assist? 1 2 3 Specify Aids:
Toileting: Ind Sup Assist/ Min Mod Max / With aids
How many people to assist? 1 2 3 Specify Aids:
Continent – Bladder Yes No / IDC SPC Incontinence Aids
Continent – Bowel Yes No / Colostomy Ileostomy Incontinence Aids
Bowel last opened
Mental State Alert Oriented Confused Known Wanderer
Depression Anxiety Dementia Acute Delirium
Residence Prior to Admission Own Home Rental Aged Care Facility
Independent Living Other
Aged Care Facility High Low Name:
Expected to return to premorbid locality Yes No

ADL'S

Domestic ADL's Driving Car Yes No

Referral

Primary Reason

Medical Psychiatric Orthopaedics Neurological Cardiac Rehabilitation Reconditioning
Pain Management Oncology Rehab Falls & Balance PD Warrior*

*Only available as a Day Rehabilitation/outpatient program. Inpatient admissions are via our Neurological program

Clinical Handover:

Consultant's Name: Speciality

Provider Number: Phone Number:

Signature: Date:

DO NOT WRITE IN THIS BINDING MARGIN