

INPATIENT/OUTPATIENT REHAB Referral Form

Please PRINT clearly.
 Fax/email to relevant facility.
 To be completed by Specialist/
 GP/Discharge Planner.
 Fax: (02) 9716 3798

PROGRAM: INPATIENT REHAB OUTPATIENT Request start date: _____

PROGRAM TYPE:

ORTHOPAEDIC RECONDITIONING FALLS PREVENTION/BALANCE CARDIAC LYMPHOEDEMA

NEUROLOGICAL PAIN MANAGEMENT RESPIRATORY METABOLIC OTHER: _____

GOALS: _____

HOSPITAL LOCATIONS:

Delmar Private Hospital Holroyd Private Hospital Longueville Private Hospital Eastern Suburbs Private Hospital

Manly Waters Private Hospital President Private Hospital The Sydney Private Hospital Minchinbury Community Hospital

PATIENT DETAILS:

Title: _____ Given names: _____ Surname: _____ Date of birth: _____ Weight (kg): _____ M F

Address: _____ Home Ph: _____ Mobile: _____

Person responsible: _____ Contact No: _____ GP Name: _____ Contact No: _____

Health Fund/DVA/Insurance Name: _____ Membership/DVA No: _____

Medicare No: _____ Ref No: _____ Expiry: _____

CLINICAL DETAILS:

Reason for Referral: _____

Recent ACAT Assessment: Y N Details: _____

Relevant Medical History: _____

Current Medications: _____

Allergies: _____

Falls History: _____

Mobility: *Bed mobility* Independent Supervision Assistance

Sit to Stand Independent Supervision Assistance

Ambulation Independent Supervision Assistance Crutches Rollator

W/Chair FASF PUF Stick/s

Weight Bearing: Full Partial Touch As Tolerated

Non weight-bearing weeks: _____

Cognitive: Intact Confusion Delirium Dementia

Hydrotherapy: Y N Commencement date: _____

Infection: Y N Details: _____

Usual Living Arrangements: Own Home Rents Hostel Nursing Home

Lives: Alone W/Partner W/Relatives W/Carer

Swallowing Intact: Yes No NGT/PEG

Diet: Normal Diabetic Tube Feed Supplement: _____

INPATIENT DETAILS:

Hospital where patient is currently located: _____ Date Admitted: _____ Hospital Ph: _____

Contact Person: _____ Referring Specialist: _____ Estimated D/C date: _____

Falls Risk: _____

Risk of Pressure Injury: Y N Wound Management: Y N

MRSA Swabs Taken: Y N Date: _____ Result: _____

Multi Resistant Organisms: Y N Type: _____

Contenance: *Bladder* Continent Incontinent IDC

Bowel Continent Incontinent Colostomy

Personal Care: Independent Requires Assistance Fully Dependent

Discharge Destination: Home Aged Care Facility Transitional Care With: _____

REFERRER'S DETAILS:

Referrer's Name: _____ Provider No: _____ Signature: _____ Date: _____

INPATIENT AND DAY REHAB Rehabilitation Referral Form

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SYDNEY METROPOLITAN REHABILITATION LOCATIONS

DELMAR PRIVATE HOSPITAL

58 Quirk St
DEE WHY NSW 2099
P 9982 7655
F 9971 7299
E Delmar@macrehab.com.au

EASTERN SUBURBS PRIVATE HOSPITAL

8 Chapel St
RANDWICK NSW 2031
P 9398 0800
F 9398 8472
E EasternSuburbs@macrehab.com.au

HOLROYD PRIVATE HOSPITAL

123 Chetwynd Rd
GUILFORD NSW 2161
P 9681 2222
F 9632 8480
E Holroyd@macrehab.com.au

LONGUEVILLE PRIVATE HOSPITAL

47 Kenneth St
LONGUEVILLE NSW 2066
P 9427 0844
F 9418 7329
E Longueville@macrehab.com.au

MANLY WATERS PRIVATE HOSPITAL

17 Cove Ave
MANLY NSW 2095
P 9977 9977
F 9977 4319
E ManlyWaters@macrehab.com.au

MINCHINBURY COMMUNITY HOSPITAL

Cnr Rupertswood Rd/Great Western Hwy
ROOTY HILL NSW 2770
P 9625 2222
F 9675 9704
E Minchinbury@macrehab.com.au

PRESIDENT PRIVATE HOSPITAL

Cnr President Ave/Hotham Rd
KIRRAWEE NSW 2232
P 9521 7788
F 9545 2659
E PresidentPrivate@macrehab.com.au

THE SYDNEY PRIVATE HOSPITAL

63 Victoria St
ASHFIELD NSW 2131
P 9716 3778
F 9716 3798
E SydneyPrivate@macrehab.com.au

