The Memorial Hospital
Inpatient Rehabilitation Referral

Email Memorial.Rehab@acha.org.au
Fax 08 8366 3703
Phone 08 8366 3785
or 0400 560 684

REFERRAL INFORMATION

Referring Hospital: _____ Date of Referral: _____

Ward: _____ Date of Admission: _____

Caller: _____ Referring Dr Provider No.: _____

Contact No.: _____

PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Phone No.: _____

Health Fund: _____

Medicare No.: _____ Health Fund Membership No.: _____

Next of Kin Name: _____ Next of Kin Contact No.: _____

MEDICAL INFORMATION

Diagnosis: _____

Operation / Procedure: _____ Date: _____

Medical History: _____

Current status:

ADLS ☐ Independent ☐ Supervision ☐ Assist 1 / 2 ☐ Full assist

Mobility ☐ Independent ☐ Assist x1 ☐ Assist x2 ☐ NWB ☐ Full / partial

Cognition ☐ Alert ☐ Orientated ☐ Cooperative ☐ Confused ☐ Dementia
☐ 4AT Mini mental score: _____

Continence ☐ Continent ☐ Incontinent - Urine ☐ Incontinent - Bowels
☐ IDC / SPC ☐ Urostomy / Colostomy

Diet ☐ Self ☐ Assist ☐ PEG / NGT

Skin integrity ☐ Intact ☐ Wound ☐ Ulcer ☐ Pressure area
Dressing type / frequency: _____

Weight: _____ Known infections status: _____

DISCHARGE PLANNING

Current accommodation: ☐ Home ☐ Respite ☐ Nursing home

Lives: ☐ Alone ☐ Family ☐ Other: _____

ACAT completed: ☐ Yes ☐ No Required: ☐ Yes ☐ No

Admitting Doctor: _____ Doctor notified of referral ☐

☐ **Funding checked** ☐ **Patient assessed** ☐ ACCEPT – Programme: _____

☐ DECLINE reason: _____ **Referring hospital notified of outcome assessment** ☐

Admission Date: _____ Admission Time: _____ Room No.: _____

Referral taken by: _____