The Memorial Hospital

Sir Edwin Smith Avenue, North Adelaide SA 5006

Phone: 08 8366 3717
Fax: 08 8366 3421

Patient Details

Name: ..... MRN: .....

DOB: ..... Gender: .....

Acute Admission Date: .....

Health Fund Name: ..... No.: .....

Inpatient Rehabilitation Referral

Health Fund Name: _____ No: _____

Current Admission Date: _____

Diagnosis: _____

Medical History: _____

_____

Social Situation: _____

GP Name: _____ Phone: _____

Next of Kin Name: _____ Phone: _____

CURRENT FUNCTIONAL STATUS:

Self Care:	Independent ☐	Assist 1 ☐	Assist 2 ☐	Dependent ☐	
Mobility:	Independent ☐	Assist 1 ☐	Assist 2 ☐	Dependent ☐	NWB ☐
Transfers:	Independent ☐	Assist 1 ☐	Assist 2 ☐	Dependent ☐	

Equipment: _____

Cognition:	Orientated ☐	Disorientated ☐	Mini Mental Score ☐		
Communication:	No Problems ☐	Some Problems ☐	Severe Problems ☐		
Urinary:	Continent ☐	Incontinent ☐	Aids _____		
Bowels:	Continent ☐	Incontinent ☐	Aids _____		
Diet:	Normal ☐	Minced ☐	Soft ☐	Vitamised ☐	Tube Feeding ☐
ACAT Assessment:	Yes ☐	No ☐	Required ☐	_____	

Date of Referral: _____ Time: _____

Name of Doctor Making Referral: _____

Funding Checked ☐ **Patient Assessed** ☐ ACCEPT ☐ Program: _____

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

ADMISSION DATE: _____ TIME: _____ ROOM No: _____

REFERRAL TAKEN BY: _____

BINDING MARGIN – DO NOT WRITE IN THIS AREA