



17-19 Solent Circuit Norwest NSW 2153
Ph: 02 8711 0247 (Rehabilitation Ward)

IN-PATIENT REHABILITATION REFERRAL FORM

PATIENT NAME:

DOB:

PLEASE FAX COMPLETED FORM TO 02 8711 0255 OR EMAIL TO rehab@lakeviewprivate.com.au

REQUESTED ADMISSION DATE:		REFERRAL DATE:	
REFERRING DOCTOR:		REFERRING HOSP:	
CONTACT NAME:		CONTACT NO:	

SECTION 1: PATIENT DETAILS

SURNAME:		GIVEN NAMES:	
TITLE:	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Other:	DATE OF BIRTH:	SEX: M / F
ADDRESS:			
PHONE (Mobile):		EMAIL:	
PHONE (Home):			
RELIGION:		MARITAL STATUS:	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Other
INDIGENOUS STATUS:	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal & Torres Strait Islander <input type="checkbox"/> Neither <input type="checkbox"/> Decline to Answer		
LANGUAGE AT HOME:		COUNTRY OF BIRTH:	
HEALTH FUND:		MEMBERSHIP NO:	
MEDICARE NO:	Exp:	VETERANS NO:	<input type="checkbox"/> White <input type="checkbox"/> Gold
NDIS PARTICIPANT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	PENSION NO:	
NEXT OF KIN:		RELATIONSHIP:	
CONTACT NO:		ADDRESS:	
GP (Family Dr):		GP CONTACT NO:	
GP ADDRESS:			

SECTION 2: FOR WORKERS COMPENSATION AND THIRD-PARTY CLAIMS ONLY

DATE OF ACCIDENT:		CLAIM NO:	
INSURANCE CO:		PHONE:	
CONTACT:		EMAIL:	

SECTION 3: MEDICAL HISTORY

REASON FOR REHABILITATION ADMISSION:	
ALLERGIES & REACTIONS:	
PAST MEDICAL HISTORY:	

SECTION 4: CLINICAL DETAILS

Current Treatments	<input type="checkbox"/> Renal Dialysis <input type="checkbox"/> Radiotherapy/ Chemotherapy <input type="checkbox"/> Cytotoxic Medication <input type="checkbox"/> Oxygen Therapy <input type="checkbox"/> PICC Line/ IVT			
Infectious Status	<input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> ESBL <input type="checkbox"/> CPE <input type="checkbox"/> COVID-19 date: <input type="checkbox"/> Other			
Falls Risk	No. of falls in current admission:			
Skin Integrity	<input type="checkbox"/> Intact	<input type="checkbox"/> Wound <i>specify</i>	<input type="checkbox"/> Pressure area <i>specify</i>	
Social History	<input type="checkbox"/> Lives Alone	<input type="checkbox"/> Lives with:	<input type="checkbox"/> Has existing homecare/ ACAT package	
Type of Accommodation	<input type="checkbox"/> Home/ Unit	<input type="checkbox"/> Retirement Village	<input type="checkbox"/> Respite	<input type="checkbox"/> High/ Low Care
Premorbid ADL Status	<input type="checkbox"/> Independent <input type="checkbox"/> Assist			
Premorbid Mobility Status	<input type="checkbox"/> Independent <input type="checkbox"/> With Aids <i>specify</i> :			
Current Mental Status	<input type="checkbox"/> Alert	<input type="checkbox"/> Confused/ Dementia/ Delirium	<input type="checkbox"/> Agitated	<input type="checkbox"/> Wanderer
Current Mobility Status	<input type="checkbox"/> Independent <input type="checkbox"/> With Aids <i>specify</i> : <input type="checkbox"/> Assist <input type="checkbox"/> Wheelchair			
Current Transfers	<input type="checkbox"/> Independent <input type="checkbox"/> Supervised <input type="checkbox"/> Assist <input type="checkbox"/> Lifter/ Hoist			
Current Self-Care Status	<input type="checkbox"/> Independent <input type="checkbox"/> Supervised <input type="checkbox"/> Assist <input type="checkbox"/> Lifter/ Hoist			
Current Continence Status	<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent of Urine	<input type="checkbox"/> IDC	<input type="checkbox"/> SPC
	<input type="checkbox"/> Doubly Incontinent	<input type="checkbox"/> Incontinent of Faeces	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Pull up pads/ night pants
Weight Bearing Status	<input type="checkbox"/> Full WB	<input type="checkbox"/> Partial WB	<input type="checkbox"/> Touch WB	<input type="checkbox"/> Non-WB
Swallowing Intact	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> NGT	<input type="checkbox"/> PEG	<input type="checkbox"/> TPN
Diet	<input type="checkbox"/> Normal <input type="checkbox"/> Diabetic <input type="checkbox"/> Other:			
Height:	cm	Weight:	kg	BMI:

