UnitingCare Health

ST STEPHEN'S HOSPITAL

Family Name: _____

Given names: _____

Address: _____

Phone: _____ DOB: _____/_____/_____

Health Fund: _____

Please Tick: ☐ **Inpatient** ☐ **Day Program**

Referral Request for Rehabilitation Services

Date of Referral: _____/_____/_____ **Doctor Referring:** _____

Provider Number: _____ **Date of admission / surgery:** _____/_____/_____

Diagnosis: _____

Relevant Medical Issues: _____

_____

_____

Previous Functional Status:

Social Situation: ☐ Lives alone ☐ Carer ☐ Care Facility ☐ Low Care ☐ High Care ☐ Other: _____

Cognition: ☐ Alert ☐ Confusion ☐ Short Term Memory Loss ☐ Depression

Current Functional Status:

Communication: ☐ Normal ☐ Other: _____ **Swallow:** ☐ Normal ☐ Impaired

Diet: ☐ Normal ☐ Soft ☐ Minced ☐ Pureed

Fluids: ☐ Normal ☐ Mildly thick ☐ Moderately thick ☐ Extremely thick

Current Level of Dependence:

	2 person	1 person	Supervise / Setup	Independent	Equipment / Aid	Comment
Transfers	☐	☐	☐	☐		
Toileting	☐	☐	☐	☐		
Showering	☐	☐	☐	☐		
Dressing	☐	☐	☐	☐		
Mobility	☐	☐	☐	☐		
Eating	☐	☐	☐	☐		
Continence	☐	☐	☐	☐		

Infection Control: ☐ MRSA ☐ VRE ☐ ESBL ☐ Other: _____

General Comments / Special Needs: _____

_____

Predicted Discharge Destination: _____ **Transport:** ☐ QAS Other: _____

Health Professional Completing Referral: _____ **DATE:** ____ / ____ / ____

Signature: _____ **Contact No:** _____

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Visiting Medical Practitioner Referral Request