ST JOSEPH'S HOSPITAL

Allied Health Outpatient Referral Form

MRN		SURNAME	
GIVEN NAME(S)			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information label)

REFERRER INFORMATION

Referred by		**Referral date**	
		Phone number	
Referring agency		**Email address**	

CLIENT INFORMATION

Name		**Date of birth**	
		Gender	☐ Male ☐ Female
Address		**Phone number**	
		Mobile number	
		Interpreter required	☐ Yes ☐ No
Funding	☐ Medicare ☐ Comprehensable ☐ DVA ☐ Overseas ineligible	**Language spoken**	
		Aboriginal or TSI	☐ Yes ☐ No
Person to contact		**Relationship to client**	
		Phone number	
Principal diagnosis		**Date of onset**	
Relevant medical history			

Identification of Risk to Clinicians

- ☐ History of violence / agression
- ☐ History of excessive alcohol / drug use
- ☐ History of contact precautions
- ☐ Hygiene / excessive clutter concerns in home environment
- ☐ Pets present in home environment
- ☐ Other / Comments:

Is the client currently at risk because of?

- ☐ Basic needs not being met
- ☐ Reduced safety secondary to communication difficulties
- ☐ Aspiration
- ☐ Falls
- ☐ Poor decision making / cognitive incapacity
- ☐ Sudden deterioration in function
- ☐ Increased carer burden
- ☐ Other / Comments:

Office Use Only

Date of Intake		
Discipline/s	☐ PT ☐ SW ☐ OT COM ☐ CAT SP ☐ NP ☐ ACC	☐ SP ☐ OT UL ☐ RITH ☐ CAT OT ☐ MRC ☐ SPAST
Priority	☐ H ☐ M ☐ L	
Commence in	☐ 1-2 weeks ☐ 4-6 weeks ☐ 6-8 weeks	
Comments		

ALLIED HEALTH OUTPATIENT REFERRAL FORM

BINDING MARGIN - NO WRITING
St Vincent's Hospital Sydney Limited
ABN 77 054 038 872

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REASON FOR REFERRAL		
Reason for referral / client goals	1. 2. 3.	
Referring for	☐ Physiotherapy ☐ Speech Pathology ☐ Neuropsychology ☐ Medical Rehabilitation Clinic	☐ Occupational Therapy ☐ Social Work ☐ Aged Care Clinic

DETAILS OF REFERRAL			
Physiotherapy			
Occupational Therapy			
Speech Pathology	☐ Apraxia of speech ☐ Dysarthria Current issues:	☐ Aphasia ☐ Dysphagia	☐ Cognitive communication deficit
Social Work			
Neuropsychology			
Medical Rehabilitation / Aged Care Clinic			

Name (print): _____ Designation: _____

Signature: _____ Date: _____

PLEASE ATTACH ANY ADDITIONAL INFORMATION TO THIS REFERRAL

NB: INCOMPLETE FORMS WILL BE RETURNED TO THE REFERRER

PLEASE RETURN COMPLETED FORMS TO SJH.ALLIEDHEALTH@SVHA.ORG.AU