ST JOSEPH'S HOSPITAL
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

Rehabilitation Services Referral

Phone: (02) 9749 0245 Email: Sjh.referral@svha.org.au

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

(Please enter information or affix Patient Information Label)

Date: _____/_____/_____ **Admit under Dr** _____

Referring Agency:_____ Ward:_____ Phone No:_____

Referring Doctor:_____ Email:_____ Contact No:_____

Referrer's Provider No:_____ Date of Referral:_____/_____/_____

Address:_____ State:_____ Postcode:_____

Patient Name:_____ D.O.B.:_____/_____/_____ Sex: ☐ Male ☐ Female ☐ Other:_____

Address:_____ State:_____ Postcode:_____

Phone:_____ COB:_____ Aboriginal or Torres Strait Islander : ☐ Yes ☐ No

Contact Person:_____ Relationship:_____

Is the patient/family aware of this referral: ☐ Yes ☐ No Religion:_____

Insurance cover: ☐ DVA ☐ Private ☐ Third Party ☐ Work Cover ☐ None

Financial Status: ☐ Compensation ☐ Medicare Ineligible ☐ Medicare ☐ Private

Interpreter Required: ☐ Yes ☐ No Preferred language other than English (LOTE):_____

Preferred language to communicate with health care provider/s:_____

Carer's Name:_____ Phone:_____ Sex: ☐ M ☐ F

Address:_____ State:_____ Postcode:_____

Living Arrangement E.g. (family, alone, etc. _____

MEDICAL DIAGNOSIS *(Include Previous Medical History)*

_____

_____

Allergies: ☐ Yes ☐ No Comments:_____

Current Infections:_____

Special Medications:_____

Patient Weight: >100 kg ☐ Yes ☐ No Weight:_____kgs Height:_____cm

Mobility	Independent	Supervision	Assist	Comments
Transfers	Pre-Morb ☐ Current ☐	Pre-Morb ☐ Current ☐	Pre-Morb ☐ Current ☐	
Walking/Wheelchair	Pre-Morb ☐ Current ☐	Pre-Morb ☐ Current ☐	Pre-Morb ☐ Current ☐	
Weight bearing status	Pre-Morb ☐ Current ☐ Full ☐	Pre-Morb ☐ Current ☐ Partial ☐	Pre-Morb ☐ Current ☐ Non weight bearing ☐	
Other precautions:				

ACTIVITIES of DAILY LIVING

	Independent	Supervision	Assist	Comments
Self care	Pre-Morb ☐ Current ☐	Pre-Morb ☐ Current ☐	Pre-Morb ☐ Current ☐	
Toileting	Pre-Morb ☐ Current ☐	Pre-Morb ☐ Current ☐	Pre-Morb ☐ Current ☐	
Feeding	Pre-Morb ☐ Current ☐	Pre-Morb ☐ Current ☐	Pre-Morb ☐ Current ☐	

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

REHABILITATION SERVICES REFERRAL

SJ110

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Continence Pre - Morbid situation

Urine incontinence	☐ Yes	☐ No	Management
Faecal incontinence	☐ Yes	☐ No	Management
IDC in-situ	☐ Yes	☐ No	Insertion date: _____/_____/_____

Swallowing

Swallowing problem	☐ Yes	☐ No	Management
Current diet	☐ Normal	☐ Modified	Specify:
Current fluids	☐ Thin	☐ Thickened	Specify:
☐ N/G	☐ PEG	Insertion date: _____/_____/_____	

Regime:

Communication

Language impairment	☐ Yes	☐ No	Comprehension/Expression:
Speech impairment	☐ Yes	☐ No	Management:

Comments:

Behaviour

☐ Yes ☐ No Comments:

Wounds

Wound	☐ Yes	☐ No	Location & Management:
Pressure ulcer	☐ Yes	☐ No	Location & Management:

Other relevant information

C Pap	☐ Yes	☐ No	Location & Management:

Specialised equipment required:

Others:

Equipment required

Arjo Bath	☐ Yes	☐ No	Management:
Large wheelchair	☐ Yes	☐ No	Management:
Tilt-in-space wheelchair	☐ Yes	☐ No	Location & Management:

Others:

Proposed discharge destination. Type of housing:

☐ House ☐ Residential Age Care

☐ Unit ☐ Other hospital

Access

Stairs, lifts, etc _____

Goal of this admission

☐ Improve function ☐ Nursing Home ☐ Hostel ☐ Home ☐ Other:_____

OFFICE USE ONLY

Patient accepted for admission? ☐ **Yes** ☐ **No** **Date of admission:**_____/_____/_____

Patient is accepted for a trial period of:_____

Signature:_____ **Position:**_____ **Date:**_____/_____/_____

NO WRITING