Aurora Westmead Rehabilitation Hospital

OUTPATIENT REFERRAL FORM

PH: (02) 88 333 555 Fax: (02) 88 333 533
E: wmd.dayprogram@aurorahealth.com.au

Surname:	DOB: / /
Given Name:	☐ Male ☐ Female
Phone: (H)	(M):
Address:	
Complete above or attach patient label	

Referrer Details

Referrer Name:	Sign:	Date:
Referring Facility:		
Specialist/GP/Surgeon:		

Funding

☐ **Self-funded / Extras cover**	☐ **DVA:** Number: Card type: Gold / White / Orange
☐ **NDIS:** Contact name: Contact phone/email:	☐ **Home Care Provider:** Contact name: Contact phone/email:
☐ **Workers Compensation / CTP / Lifetime Care** Insurer: Claim no.: Contact name/number/email:	

Diagnosis and Disability

Primary Diagnosis:
Relevant Medical History:
Current Status:

Therapies Required

❑ Physiotherapy	❑ Exercise Physiology
❑ Occupational Therapy	❑ Dietician
❑ Speech Pathology	❑ Hydrotherapy (please complete back page)

Reasons for Referral and Goals of Therapy

Special Requirements (Please tick any/all that apply)

❑ 1:1 INITIAL ❑ 1:1 ALL SESSIONS

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Hydrotherapy checklist (if applicable:

BLADDER

Does the patient currently have, or have a history of, urinary tract infection? **Yes / No**

Is the patient incontinent of urine? **Yes / No**

Does the patient have a urinary catheter? **Yes / No**

BOWELS

Is the patient incontinent of faeces to any degree? **Yes / No**

Does the patient have diarrhoea? **Yes / No**

Does the patient have a colostomy with an appliance that cannot be sealed? **Yes / No**

Does the patient have an ileostomy? **Yes / No**

SKIN

Does the patient have a wound? **Yes / No**

Does the patient have an infected wound? **Yes / No**

Does the patient have an exfoliative or suppurative skin condition, or any sores or lesions on the skin or dermatitis?

Yes / No

CARDIAC/RESPIRATORY

Does the patient have any cardiac condition, including cardiac failure / pacing / transplant? **Yes / No**

Does the patient have a productive cough? **Yes / No**

BEHAVIOURAL

Does the patient have a poor level of personal hygiene? **Yes / No**

Does the patient have difficulty following directions or requests? **Yes / No**

If the answer is YES to any of the above, please provide details: