Westmead Rehabilitation Hospital

INPATIENT REHABILITATION / MEDICAL REFERRAL

Unit Record Number ☐☐☐☐☐☐☐☐

Family Name _____

Given Names _____

Date of Birth ☐☐☐☐☐☐☐☐ Age ☐☐

Sex ☐ Room No. ☐☐☐

OR USE LABEL

Please complete and fax to on: 8833 3533 or email to westmead@pulsehealth.net.au

1. Patient & Fund Details:

Patient Name:	DOB:	Age:
Address:		
Sex: ☐ Male ☐ Female	Marital Status: M S W D	☐ Single Room Requested
Phone:	Religion:	Country of Birth:
Next of kin:	Relationship:	Phone:
Medicare No:	Expiry date:	Pension No.
Private Health Fund / DVA:	Health Fund / DVA Membership No:	
Is this injury as a result of an insurable accident? ☐ Yes ☐ No		
☐ WC ☐ CTP	Insurance Co.:	Claim No:
Case Manager:	Phone:	Email:

2. Referral Details:

Date of Referral:	Person Referring:	Relationship:
Referring from: ☐ Home ☐ Hospital		
Date of Referring Hospital Admission:	Ward:	Phone:
Referring Specialist or GP details:	Email:	Phone:
Specialist / GP Rooms Address:		
Expected Date of Admission to WRH:	Previous patient at WRH: ☐ Yes ☐ No	

Preferred Rehab Specialist: ☐ Dr Malcolm Bowman ☐ A/Prof Ian Baguley ☐ Dr Alex Ganora ☐ Dr Jane Wu ☐ Dr Anthony Suen ☐ No Preference

3. Clinical Details:

Diagnosis / Operation: _____ Operation Date: _____

If joint replacement: ☐ Elective ☐ Result of Fracture Allergies: ☐ Yes ☐ No

Relevant history: _____ MRSA: ☐ Yes ☐ No

_____ Other organisms: _____

Current Medications: _____

_____

Cognitive Status: ☐ Alert ☐ Orientated ☐ Co-operative ☐ Confused ☐ Dementia

Medical Requirements: ☐ O^2 ☐ IV / CVC / PICC (circle) Home O^2 ☐ Yes ☐ No

Mobility / Transfers: ☐ Supervision ☐ Assist _____ person(s) ☐ Min ☐ Mod ☐ Max ☐ With aids: _____

Mobility Aid: ☐ Yes, type: _____ ☐ No

Weight bearing status: ☐ FWB ☐ WBAT ☐ PWB ☐ TWB ☐ NWB (for _____ more wks)

Showering / Dressing: ☐ Supervision ☐ Assist _____ person(s) ☐ Min ☐ Mod ☐ Max ☐ With aids: _____

Toileting: ☐ Supervision ☐ Assist _____ person(s) ☐ Min ☐ Mod ☐ Max ☐ With aids: _____

Continence: ☐ Continent ☐ Incontinent Urine ☐ Incontinent Faeces ☐ SPC ☐ IDC ☐ Colostomy

Nutrition: ☐ NGT ☐ PEG ☐ Diabetic ☐ Diet: _____ ☐ Supplements: _____

Skin Integrity: ☐ Intact ☐ Wound ☐ Pressure Areas ☐ Type of dressing and frequency _____

Physical: ☐ Weight (kgs) _____ ☐ Hb _____ Date last taken _____

Bariatric equipment required? ☐ Yes ☐ No If yes, what equipment is required: _____

Social situation: ☐ Lives alone ☐ Lives with partner / spouse ☐ Lives with relative ☐ Lives with carer

Type of accommodation: ☐ Home / unit ☐ Retirement village ☐ Nursing Home ☐ Hostel

WESTMEAD OFFICE USE ONLY

Admission Type: ☐ Medical ☐ Rehab (specify): ☐ Ortho Upper ☐ Ortho Lower ☐ Reconditioning

Assessment completed by: _____ Admission date: _____

Referral accepted ☐ Yes ☐ No Date: _____ Accepting Specialist: _____

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MR/2A

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