Bass Coast Health
Inpatient Services Referral

Ph: 03 5671 3384 Fax: 03 5671 3321

Name: _____
Address: _____
_____
Phone: _____
D.O.B: _____ **Sex:** Male/Female
MRN: _____
GP: _____
Affix Bradma Label Here

Referral to: Health Service: .....
Bed Type *(i.e. Acute, Rehab, GEM)* : .....

Referrer Details

Organisation: ..... Date of Referral: .....
Unit: ..... Contact Person: .....
Phone: ..... Fax: ..... Alternate Contact Number: .....
Reason for Referral: .....
.....
Name, Designation of Referrer: ..... Date: .....

Patient's Medical Details at Referral

Anticipated date of transfer: ..... Date of Acute Onset: .....
Diagnosis / Medical Notes or Presenting illness: .....
.....
.....
.....
Any Ongoing Acute Medical Issues: .....
.....
Past Medical / Psych History: .....
.....
.....
Allergies/Adverse Drug Reactions: .....

Consent

Does the patient consent to referral?
☐ Yes ☐ No If no, why? .....

Infections

Does the patient have any infectious risks?
☐ MRSA ☐ VRE ☐ CPE ☐ Other, Specify .....

Patient Details

Name of NOK: .....
Relationship: .....
Telephone: .....
Contact (If different from NOK) .....
Relationship: .....
Telephone: .....

Guardian / Administrator

Power of Attorney ☐ Yes ☐ No
Details: .....
Case Manager: .....
Care Package Type: .....
☐ Work Cover No: .....
Private Health ☐ Yes ☐ No

Patient Goals and Expectations:

Name: _____

Address: _____

Phone: _____ **DOB:** _____

MRN: _____ **Sex:** _____

GP:

Affix bradma label here

Advanced Care Planning

Does the patient have an Advanced Care Directive?

☐ Yes ☐ No Details: .....

Anticipated Discharge Destination Post Inpatient Rehabilitation / GEM

☐ Home ☐ Other .....

☐ ACAS assessment – Date: ..... Residential Care: ☐ Low Level ☐ High Level

Social / Family Supports

Lives:

☐ Alone ☐ Family ☐ Other: .....

☐ House ☐ Flat / Unit ☐ Aged Care Facility ☐ Other .....

Previous Services Received:

☐ MOW ☐ Home Care ☐ District Nursing ☐ Other: .....

Please comment on patient's level of function prior to this event (i.e. ADLs, mobility etc.):

.....

.....

Current Physical Function

Weight Bearing Status

☐ Non WB ☐ Touch WB ☐ Partial WB ☐ WB as tolerated ☐ Full WB

Falls Risk: ☐ High ☐ Medium ☐ Low **Recent Falls:** .....

High Risk Strategies (i.e. Exit Alarm, Visual Observations)

Mobility / Transfers: ☐ Independent ☐ Supervision ☐ Assist ☐ Dependent

Aids: ..... Endurance: .....

Own Equipment: ☐ Yes ☐ No

Activities of Daily Living ☐ Independent ☐ Supervision ☐ Assist ☐ Dependent

Other Physical Issues: .....

.....

Nutrition / Diet

Weight: ..... Date: .....

Dietary Requirements: ☐ Full Ward Diet ☐ Modified Diet ☐ Enteral Feeding ☐ Other

Details: .....

Communication

Are there any communication difficulties? ☐ No ☐ Yes

Details: .....

Is English the patient's first language? ☐ No ☐ Yes

If no, what is their main language: .....

Is an interpreter required? ☐ No ☐ Yes

Name: _____

Address: _____

Phone: _____

DOB: _____

MRN: _____ **Sex:** Male/Female

GP:

Is the client: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander ☐ Neither

Cognition / Behaviour *Are there any Cognitive Concerns:* ☐ No ☐ Yes

Are there any Behavioural Concerns: ☐ No ☐ Yes

Details: .....

Does patient exhibit any withdrawal symptoms: ☐ No ☐ Yes Details: .....

Does the patient require Visual Observations / Bed Alarm: ☐ No ☐ Yes Details: .....

Cognitive Assessment: ..... Score: ..... Date: ..... Report Attached ☐

Neuropsychiatric Cognitive Assessment (NUCOG) Score: ..... Date: ..... Report Attached ☐

Elimination Bladder: ☐ Continent ☐ Incontinent ☐ Catheter ☐ Other .....

Bowels: ☐ Continent ☐ Incontinent ☐ Stoma ☐ Other .....

Continence Aids used: .....

Skin Integrity / Wounds

Location: ..... Aetiology: ..... Duration: .....

☐ Acute ☐ Chronic Pressure Area Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A

Further Details: ..... Report Attached ☐

Medications

List of current medications and recent medication changes: (*Attaching copy of current drug chart and Medication Reconciliation Form / Medication Management Plan will suffice*)

.....

.....

Special Treatment and Equipment Needs *(Please provide details)*

☐ Dialysis ..... ☐ IV Therapy / Antibiotics .....

☐ Bariatric ..... ☐ Oxygen .....

☐ Other (Braces, Splints, orthosis, prosthesis, pressure equipment) .....

.....

Follow Up Tests / Appointments

Date	Time	Test / Appointment	Location

IMPORTANT - Please ensure that all relevant supporting documents are attached to the referral
(Allied Health Assessments, Medication Chart / Reconciliation Form, Recent Pathology, Discharge Summary etc.)

MRN:	Name:	DOB:

OFFICE USE ONLY:

Date Referral Received: ..... Date of Acceptance (if applicable): .....

Outcome of Referral: .....

.....

Name & Designation: ..... Signed: .....