る 「 で し し し し し し し	First Name Gender Date of Birth/ Age
Bass Coast Health	Date of Birth/ Age Age
npatient Services Referral	Address
•	PLACE LABEL HERE
Please send via seco	ure email to: hscteam@basscoasthealth.org.au
Patient Surname:	Date of birth: / /
Patient Given name(s):	Gender:
Patient Address:	
Referral to: Health Service:	
Bed Type (i.e. Acute, Rehab, GEM):	
For all stroke rehabilitation and amputee	rehabilitation, please contact the Geriatrician Registrar via Bass
	or the Health Services Coordinator on 5671 3384
Referrer Details	
	Date of Referral: / /
	Contact Person:
	te Contact Number:
	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:	

* B C H 3 2 8 0 *

BCH, V1 May 2023 Page 1 of 4

INDATIENT SERVICES REEERDAI

MR/280

	Surname U.R. No			
	First Name Gender			
Base Coast Lingth	Date of Birth			
Bass Coast Health				
	Doctor Ward			
Inpatient Services Referral	Address			
	PLACE LABEL HERE			
Past Medical / Mental Health History:				
Allergies/Adverse Drug Reactions:				
Infections				
Does the patient have any infectious risks				
	Other, Specify:			
Covid Vaccination Exposure Ward Environ				
Date of Covid Vaccination:/	_/			
Recent Covid Exposure: /	_/			
Ward environment includes Covid Posi	tive patients: 🗆 Yes 🛛 No			
□ PCR Date://	Result:			
□ Rat Date://				
Next of Kin (NOK) Details	Guardian / Administrator			
Name of NOK:				
Relationship:				
Telephone:				
Contact (If different from NOK):				
Relationship:				
Telephone:	Private Health: Yes No			
Patient Goals and Expectations:				
Anticipated Discharge Destination:				
Advanced Care Planning				
_	Directive? 🗆 Yes 🗆 No Details:			
Social / Family Supports				
	Other:			
	Aged Care Facility			
	Home Care 🛛 District Nursing 🖓 Other:			

INPATIENT SERVICES REFERRAL

MR/280

npatient Services Referral	Surname U.R. No
Please comment on patient's premorbi	d level of function
Current Physical Function	Kgs BMI:
Weight Bearing Status:	
-	Low Recent Falls:
	Endurance:
Own Equipment:Image: YesImage: NoActivities of Daily Living:Image: Image:	nt 🗆 Supervision 🗆 Assist 🗆 Dependent
□ Attach Physiotherapist report □	Attach Occupational Therapist report
Nutrition / Diet Dietary Requirements: Full Ward Diet Details:	Modified Diet Enteral Feeding Other
Communication	
Are there any communication difficulties?	□ Yes □ No
Details:	
Speech Pathology Input Report at	tached
-	there any Cognitive Concerns:
Are there any Behavioural Concerns: D	/es 🗆 No
	Score: Date: 🗆 Report Attached
Nouropsychiatric Cognitive Accessment (N	NOCOGI SCORE Date LA Report Attached
Neuropsychiatric Cognitive Assessment (N	
Neuropsychiatric Cognitive Assessment (N Elimination Bladder: □	t 🗆 Catheter 🗆 Other:

BCH, V1 May 2023 Page 3 of 4

Inpatient Services Referral Doctor Ward Address PLACE LABEL HERE Skin Integrity / Wounds Duration: Acute Chro Pressure Area Stage: 1 2 3 4 N/A Further Details: Corrent medications and recent medication changes: (Attaching copy of current drug chart and Medication Reconciliation Form / Medication Management Plan will suffice) Details attached Details attached Corrent Special Treatment and Equipment Needs (Please provide details) IV Therapy / Antibiotics: 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.) Please send via secure email to: hscteam@basscoasthealth.org.au Enquiries to Health Services Coordinator on 5671 3384 OFFICE USE ONLY: MRN: Date of Acceptance (if applicable): Outom of Referral: Name & Designation: Signed: Signed: BCH Accepting MO Reviewed by Geriatrician / registrar Signed: Signed:		Bass Coas	SIH st Health	First Name Date of Birth	IĘNŢ	U.R. No
Location:	Inpatient S	Services F	Referral			
List of current medications and recent medication changes: (Attaching copy of current drug chart and Medication Reconciliation Form / Medication Management Plan will suffice) Details attached Special Treatment and Equipment Needs (Please provide details) NUTherapy / Antibiotics: 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.) Please send via secure email to: hscteam@basscoasthealth.org.au Enquiries to Health Services Coordinator on 5671 3384 OFFICE USE ONLY: MRN: Date of Acceptance (if applicable): Date Referral Received: Date of Acceptance (if applicable): Date Accepting MO	Location: Pressure Area S	Stage: 🗆 1		□ 4 □ N/A		
IV Therapy / Antibiotics: 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.) Please send via secure email to: hscteam@basscoasthealth.org.au Enquiries to Health Services Coordinator on 5671 3384 OFFICE USE ONLY: MRN: Name: Date Referral Received: Date of Acceptance (if applicable): Outcome of Referral: Name: Name & Designation: Signed: BCH Accepting MO Signed:	List of current r Medication Reco	onciliation Fo		5	5 15	of current drug chart and
Date Time Test / Appointment Location Important Location 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.) Please send via secure email to: hscteam@basscoasthealth.org.au Enquiries to Health Services Coordinator on 5671 3384 OFFICE USE ONLY: MRN:	 IV Therapy / Oxygen: 	Antibiotics:				
Health Assessments, Medication Chart / Reconciliation Form, Recent Pathology, Discharge Summary etc.) Please send via secure email to: hscteam@basscoasthealth.org.au Enquiries to Health Services Coordinator on 5671 3384 OFFICE USE ONLY: MRN:		ta / Annaint		, p	nent)	
Health Assessments, Medication Chart / Reconciliation Form, Recent Pathology, Discharge Summary etc.) Please send via secure email to: hscteam@basscoasthealth.org.au Enquiries to Health Services Coordinator on 5671 3384 OFFICE USE ONLY: MRN:	-			· · · ·		
MRN: Name: DOB: Date Referral Received: Date of Acceptance (if applicable):	-			· · · ·		
Date Referral Received: Date of Acceptance (if applicable): Outcome of Referral: Name & Designation: BCH Accepting MO	Date	Time Please ensure ents, Medicat Please se	Test / Ap	ant supporting docu econciliation Form, Re	ments are attac ecent Patholog n@basscoast	Location ched to the referral (Allied y, Discharge Summary etc.)
Outcome of Referral:	Date	Time Please ensure ents, Medicat Please se	Test / Ap	ant supporting docu econciliation Form, Re	ments are attac ecent Patholog n@basscoast	Location ched to the referral (Allied y, Discharge Summary etc.)
Name & Designation: BCH Accepting MO	Date IMPORTANT - F Health Assessme OFFICE USE ONLY MRN:	Time Please ensure ents, Medicat Please se	Test / Ap	ant supporting docur econciliation Form, Re re email to: hsctear Health Services Coorc	ments are attac ecent Patholog n@basscoast linator on 5671	Location Loc
BCH Accepting MO	Date IMPORTANT - F Health Assessme OFFICE USE ONLY MRN: Date Referral R	Time Please ensure ents, Medicat Please se f: c:	Test / Ap	ant supporting docur econciliation Form, Re re email to: hsctear Health Services Coorce ne: Date of Accep	ments are attac ecent Patholog n@basscoast linator on 5671 tance (if applic	Location Loc
	Date IMPORTANT - F Health Assessme OFFICE USE ONLY MRN: Date Referral R Outcome of Re	Time Please ensure ents, Medicat Please se f: c: ferral:	Test / Ap	ant supporting docur econciliation Form, Re e email to: hsctear Health Services Coorce ne: Date of Accep	ments are attac ecent Patholog n@basscoast linator on 5671 tance (if applic	Location Loc
	Date IMPORTANT - F Health Assessme OFFICE USE ONLY MRN: Date Referral R Outcome of Re Name & Design	Time Time Please ensure Please ensure Please se	Test / Ap	ant supporting docur econciliation Form, Re re email to: hsctear Health Services Coorce ne: Date of Accep	ments are attac ecent Patholog n@basscoast linator on 5671 tance (if applic Signed:	Location Loc

BCH, V1 May 2023 Page 4 of 4