



Inpatient Services Referral

Surname U.R. No.
 First Name Gender
 Date of Birth / / Age
 Doctor Ward.....
 Address

PLACE LABEL HERE

Past Medical / Mental Health History:

.....

Allergies/Adverse Drug Reactions:

.....

Infections

Does the patient have any infectious risks?

MRSA VRE CPE ESBL Other, Specify:

Covid Vaccination Exposure Ward Environment

Date of Covid Vaccination: ____ / ____ / ____

Recent Covid Exposure: ____ / ____ / ____

Ward environment includes Covid Positive patients: Yes No

PCR Date: ____ / ____ / ____ Result:

Rat Date: ____ / ____ / ____ Result:

Next of Kin (NOK) 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 – If yes, No:

Private Health: Yes No

Patient Goals and Expectations:

.....

Anticipated Discharge Destination:

Advanced Care Planning

Does the patient have an Advanced Care Directive? Yes No Details:

Social / Family Supports

Lives: Alone Family Other:

House Flat / Unit Aged Care Facility Other:

Previous Services Received: MOW Home Care District Nursing Other:

INPATIENT SERVICES REFERRAL

MR/280



Inpatient Services Referral

Surname U.R. No.
 First Name Gender
 Date of Birth / / Age
 Doctor Ward
 Address

PLACE LABEL HERE

Please comment on patient's premorbid level of function

Current Physical Function

Height: _____ cm Weight: _____ Kgs BMI: _____

Weight Bearing Status: _____

Falls Risk: High Medium Low Recent Falls: _____

Mobility / Transfers: Independent Supervision Assist Dependent

Aids: _____ Endurance: _____

Own Equipment: Yes No

Activities of Daily Living: Independent Supervision Assist Dependent

Attach Physiotherapist report Attach Occupational Therapist report

Nutrition / Diet

Dietary Requirements: Full Ward Diet Modified Diet Enteral Feeding Other

Details: _____

Communication

Are there any communication difficulties? Yes No

Details: _____

Speech Pathology Input Report attached

Cognition / Behaviour

Are there any Cognitive Concerns: Yes No

Are there any Behavioural Concerns: Yes No

Provide Details: _____

Cognitive Assessment: _____ Score: _____ Date: _____ Report Attached

Neuropsychiatric Cognitive Assessment (NUCOG) Score: _____ Date: _____ Report Attached

Elimination

Bladder: Continent Incontinent Catheter Other: _____

Bowels: Continent Incontinent Catheter Other: _____

INPATIENT SERVICES REFERRAL

MR/280



Inpatient Services Referral

Surname U.R. No.
 First Name Gender
 Date of Birth / / Age
 Doctor Ward.....
 Address

PLACE LABEL HERE

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)*

Details attached

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: Name: DOB:
 Date Referral Received: Date of Acceptance (if applicable):
 Outcome of Referral:
 Name & Designation: Signed:
 BCH Accepting MO
 Reviewed by Geriatrician / registrar

INPATIENT SERVICES REFERRAL

MR/280