Inpatient Services Referral

Surname ..... U.R. No. .....

First Name ..... Gender .....

Date of Birth ..../..../.... Age .....

Doctor ..... Ward .....

Address .....

PATIENT LABEL

PLACE LABEL HERE

Please send via secure 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 Coast Health Switchboard on 5671 3333 or the Health Services Coordinator on 5671 3384

Referrer Details

Organisation: _____ Date of Referral: _____ /_____ /_____

Ward: _____ Contact Person: _____

Phone: _____ 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:

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MR/280

BCH3280

BCH Bass Coast Health

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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: _____

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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: _____

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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 _____

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