

MRN			VMO	
Surname				
Given Names				
Address				
		Ph:		
Gender	Age	DOB		
<i>(Please enter information or affix patient label)</i>				

Admissions Manager  
Ph: (02) 9427-0844 Fax: (02) 9427-8769

**PROGRAM:**     **MEDICAL**             **INPATIENT REHABILITATION**             **HEART WELLNESS**  
 **OUTPATIENT**             **DAY ONLY REHABILITATION**

1. PATIENT DETAILS:

Patient's Name: _____	DOB: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: _____ Religion: _____
Address: _____	
Telephone: _____	Mobile: _____ Country of Birth: _____
Next of Kin: _____	Relationship: _____ Telephone: _____
Medicare No: _____	Expiry Date: _____
DVA No: _____	Pension No: _____
Private Health Fund: _____	Membership No: _____
WC/CTP Insurance Co: _____	Claim No: _____
Case Manager: _____	Telephone: _____
Case Manager Email: _____	

2. REFERRAL DETAILS:

Expected Date of Admission to LPH: _____	Date of Referral: _____
Person Referring: _____	Expected Length of Stay: _____
Referring from: <input type="checkbox"/> Home	Referring GP: _____
GP Address: _____	
Telephone: _____	Fax: _____
Referring Hospital: _____	Ward: _____ Telephone: _____
Original Date of Admission: _____	Prev Hospital if any: _____
Referring Specialist: _____	Telephone: _____
Specialist Rooms Address: _____	
Multi Resist Organism Status: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> ESBL	
<input type="checkbox"/> Other: _____	Date of Swabs: _____
Has the ward had any gastro / flu in the past 4 days: <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient affected: <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Doctor/Rehab Specialist: _____	

3. CLINICAL DETAILS:

Diagnosis/Operation: _____	Operation Date: _____
Relevant History: _____	
Current Medications: _____	
Cognitive Status:	Allergies: _____
<input type="checkbox"/> Alert	<input type="checkbox"/> Orientated
<input type="checkbox"/> Dementia	<input type="checkbox"/> Co-operative
<input type="checkbox"/> O2	<input type="checkbox"/> Confused
<input type="checkbox"/> IV	<input type="checkbox"/> Aggression
<input type="checkbox"/> CVC	<input type="checkbox"/> PICC
<input type="checkbox"/> Assist _____ person(s)	<input type="checkbox"/> Supervision
<input type="checkbox"/> Hoist	<input type="checkbox"/> Independent
Mobility: <input type="checkbox"/> Immobile	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> 2WW / PUF	<input type="checkbox"/> FASF
<input type="checkbox"/> Stick / Crutches	<input type="checkbox"/> 4WW / LRF
<input type="checkbox"/> No Aids	<input type="checkbox"/> Independent
Weight Bearing Status: <input type="checkbox"/> FWB	<input type="checkbox"/> WBAT
<input type="checkbox"/> PWB: _____ %	<input type="checkbox"/> TWB
	<input type="checkbox"/> Protected WBAT
	<input type="checkbox"/> NWB (for _____ wks)



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3. CLINICAL DETAILS (CONT'D):

ADL's:	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervision	<input type="checkbox"/> Moderate Assist	<input type="checkbox"/> Minimal Assist
	<input type="checkbox"/> Full Assist	<input type="checkbox"/> Aids: _____		
Continence:	<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent Urine	<input type="checkbox"/> Incontinent Faeces	
	<input type="checkbox"/> SPC	<input type="checkbox"/> IDC	<input type="checkbox"/> Colostomy	
Feeding:	<input type="checkbox"/> Self	<input type="checkbox"/> Assist	<input type="checkbox"/> NGT	<input type="checkbox"/> PEG
Nutrition:	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Supplements: _____		
	<input type="checkbox"/> Diet: _____			
Skin Integrity:	<input type="checkbox"/> Intact	<input type="checkbox"/> Wound	<input type="checkbox"/> Pressure Areas	<input type="checkbox"/> Ulcers
	<input type="checkbox"/> Type of Dressing: _____		Frequency: _____	
Physical:	<input type="checkbox"/> Weight (kgs): _____		Hb: _____	Date last taken: _____
Specialist Equipment:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, equipment: _____	
Social Situation:	<input type="checkbox"/> Home	<input type="checkbox"/> Self-Care Unit	<input type="checkbox"/> Hostel	<input type="checkbox"/> Nursing Home
Pre-Admission Support:	<input type="checkbox"/> Self	<input type="checkbox"/> Live in Spouse/Carer	<input type="checkbox"/> Community Service	
	<input type="checkbox"/> Non Live in Care			
Rehabilitation Goals:	1. _____			
	2. _____			
	3. _____			
Other Comments:	_____			
	_____			

BINDING MARGIN - DO NOT WRITE

**Please Note:**

When a patient is transferred to Longueville Private Hospital, please ensure the following accompanies the patient:

- Appropriate discharge summaries (medical, nursing, allied health, list of medications, etc).
- Three days of Medication supply
- Details of follow up appointment(s)
- Copies of report of relevant investigations (x-rays, pathology).

Heart Wellness Patient Referrals **MUST** include:

- Most Recent Letter from the Cardiologist
- Most recent Echocardiogram result
- Most recent Stress Echocardiogram result if available

Longueville Private Hospital Office Use Only:

Telephone Assessment Conducted:  Yes  No Date: \_\_\_\_\_

Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Face to Face Assessment Conducted:  Yes  No Date: \_\_\_\_\_

Patient agrees to transfer to Longueville Private Hospital if accepted:  Yes  No

Patient aware of, and agrees to participate in, therapy:  Yes  No

Patient informed of costs/health fund excess or co-payment (if applicable) and other charges such as Allied Health / transport to and from hospital:  Yes  No

Additional Information: \_\_\_\_\_

Assessor: \_\_\_\_\_ Signed: \_\_\_\_\_ Date: \_\_\_\_\_