

|                                                   |  |     |     |     |     |
|---------------------------------------------------|--|-----|-----|-----|-----|
| MRN                                               |  |     | VMO |     |     |
| Surname                                           |  |     |     |     |     |
| Given Names                                       |  |     |     |     |     |
| Address                                           |  |     |     |     |     |
|                                                   |  |     |     |     | Ph: |
| Gender                                            |  | Age |     | DOB |     |
| (Please enter information or affix patient label) |  |     |     |     |     |

### REFERRAL SUBMISSION:

Email: lphadmin@machealth.com.au

Phone: (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: _____                                                                                                                                                                         |                           | Fax: _____                     |                              |
| Telephone: _____                                                                                                                                                                          | 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"/> Co-operative        | <input type="checkbox"/> Confused    |
| <input type="checkbox"/> Dementia                   | <input type="checkbox"/> Absconding Risk        | <input type="checkbox"/> Aggression          |                                      |
| Medical Requirements:                               | <input type="checkbox"/> O2                     | <input type="checkbox"/> IV                  | <input type="checkbox"/> CVC         |
| Transfers: <input type="checkbox"/> Hoist           | <input type="checkbox"/> Assist _____ person(s) | <input type="checkbox"/> Supervision         | <input type="checkbox"/> Independent |
| Mobility: <input type="checkbox"/> Immobile         | <input type="checkbox"/> Wheelchair             | <input type="checkbox"/> FASF                | <input type="checkbox"/> 4WW / LRF   |
| <input type="checkbox"/> 2WW / PUF                  | <input type="checkbox"/> Stick / Crutches       | <input type="checkbox"/> No Aids             | <input type="checkbox"/> Independent |
| Weight Bearing Status: <input type="checkbox"/> FWB | <input type="checkbox"/> WBAT                   | <input type="checkbox"/> Protected WBAT      |                                      |
| <input type="checkbox"/> PWB: _____ %               | <input type="checkbox"/> TWB                    | <input type="checkbox"/> NWB (for _____ wks) |                                      |

|                                                   |  |     |     |     |           |
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| MRN                                               |  |     | VMO |     |           |
| Surname                                           |  |     |     |     |           |
| Given Names                                       |  |     |     |     |           |
| Address                                           |  |     |     |     |           |
|                                                   |  |     |     |     | Ph: _____ |
| Gender                                            |  | Age |     | DOB |           |
| (Please enter information or affix patient label) |  |     |     |     |           |

Admissions Manager

Ph: (02) 9427-0844

Fax: (02) 9427-8769

## 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:                                                                                                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date: _____ |
| Contact: _____                                                                                                                                       | Telephone: _____             |                             |             |
| Face to Face Assessment Conducted:                                                                                                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date: _____ |
| Patient agrees to transfer to Longueville Private Hospital if accepted:                                                                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |             |
| Patient aware of, and agrees to participate in, therapy:                                                                                             | <input type="checkbox"/> Yes | <input type="checkbox"/> 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: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |             |
| Additional Information:                                                                                                                              | _____                        |                             |             |

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