Patient ID Label

1 Emu Street, Strathfield NSW 2135
Tel. (02) 9747 5333 **Please fax to: (02) 8745 2250**

REFERRAL FORM

REFERRAL DATE: / /

☐ **In-patient** ☐ **Single Room requested**

Room Assigned (Alwyn) ________

Patient's Name______________________________ ☐ Male ☐ Female **DOB** / /

Address ______________________________ ___________ Country of Birth ________________

Telephone____________________________ Religion ___________ NESB ☐ Language spoken ____________

Next-of-Kin ____________________________ _____ Relationship. __________Tel. ____________________

NOK Address ____

REFERRING HOSPITAL: ______________________________ ____________________ **Ward:** ________________

Referring Hospital Contact: ______________________________ **Telephone** ______________________

Referring Specialist: ______________________________ **Telephone** ______________________

Specialist Rooms Address ____

GP Name: ______________________________ **Telephone** ______________________

Address ____

Expected Date of Admission to Alwyn: / / | *Previous Patient at Alwyn* ☐ NO ☐ YES | *Alwyn* MRN __________

CLINICAL DETAILS

Diagnosis/Operation .... Operation Date: / /

Relevant History: ....

.... **Falls Risk:** ☐ Low ☐ Med ☐ High

Cognitive Status: ☐ Alert ☐ Orientated ☐ Cooperative ☐ Confused ☐ Dementia

Mobility/transfers: ☐ Independent ☐ Assist ____ Person(s) ☐ Hoist **Mobility Aid**? (*type*) ....

Weight bearing status: ☐ FWB ☐ WBAT ☐ PWB ☐ TWB ☐ NWB (*for* ____ *more weeks*)

ADLs: ☐ Independent ☐ Supervision ☐ Min Assist ☐ Mod Assist ☐ Max Assist

Continence: ☐ Continent ☐ Incontinent Urine / Faeces ☐ SPC ☐ IDC ☐ Colostomy

Skin Integrity: ☐ Intact ☐ Pressure Areas .... ☐ Skin Tear.......................... ☐ Wound ....

Type of Dressing & Frequency: ....

Nutrition: ☐ Diet .... ☐ Supplements................................ ☐ Diabetic ☐ PEG

Social Situation: ☐ At home - *(circle)* independent / carer / community supports .... ☐ Hostel /N.Home

HA Infection: ☐MRSA ☐ VRE ☐ Cd Other...................... (*site*) .... *Swabs* ....

Recent Communicable diseases .... ☐Hx Psychiatric Illness .... ☐ Wgt. .... kgs

Medical requirements: ☐O2 .... ☐ Hb .... (*Date taken*) .... **Expected destination on discharge**: ....

HEALTH FUND ___________ Level of Cover ____________________ Membership No.________________________

Medicare No: ____________________ No __________

Expiry Date ____ / ____ DVA No ____________________

Pension Number ________________________________

Safety Net or Concession No ________________________

WORKCOVER / THIRD PARTY

Insurer ____

Claim Number ___________________________________

Case Manager ___________________________________

Telephone No. ___________________________________

Fees payable at Alwyn: ....