Dhelkaya Health

Connolly Rehabilitation Unit Referral

P.O. Box 50, Castlemaine Vic 3450
Ph: 03 5471 3595
Email: rehab@castlemainehealth.org.au

UR NO ………………….. DOB ……………………….

SURNAME……………………………………………………..

GIVEN NAME……………………………………………………

AFFIX PATIENT LABEL HERE

Inpatient GEM: ☐	Inpatient Rehabilitation: ☐	TCP: ☐
Present Location:		Ph:
NOK:	Relationship:	Ph:
Referring Doctor:	GP:	
Pension No:	DVA No:	WorkCover:
Private Health Fund:	TAC:	

ACAS Approval for: TCP ☐ Low Level Respite ☐ High Level Respite ☐ Permanent Care ☐

1. Diagnosis: ……………………………………………………………………………………………………
……
Please attach Medical Discharge Summary – referral will not be accepted without

2. Medical Management Plan: (follow up appointments / investigations) (attach GP Health Summary)
……
……

3. Reason for Referral: ……………………………………………………………………………………
……

4. Patient Goals: (↑ Endurance, ↑ Balance, ↓ Falls Determine Discharge destination) ………………
……
…………………………………………………………………… **Estimated length of stay:…………**

5. Medical History: (please attach copy of medication, pathology and radiology) ……………………
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……

6. Social History: (home environment, family, support person, services, case manager) ………………
……
……

Advanced Care Directive: Yes / No	POA: Medical Yes / No Financial Yes / No (provide copy)	
Weight ……………………kg	BP ……………………………	O_2 Sats …………………………
BMI ………………………	Pulse …………………………	Temp …………………………
Infectious Risk …………………	MRSA …………………………	Bowel Frequency ……………

Transmission blood precautions required: Contact ☐ Droplet ☐ Airborne ☐ Protective Isolation ☐

Mobility / Transfers: Independent ☐ Assistance ☐ Immobile ☐ Wanders: Yes / No
Aid Required ☐ Specify :

Mental State / Behaviours: Normal ☐ Minor Changes Confused ☐ Depressed ☐ APMH ☐
Aggressive ☐ Delirium ☐ Other ☐ Wanders: Yes / No Abscond Risk: Yes / No

Pressure Areas: Yes / No Specify:

Wounds: Yes / No Specify:

Vision Impairment: Yes / No	Hearing Impairment: Yes / No

Continent: Bladder Yes / No Bowel Yes / No Aid Required ☐ Specify:

Does patient and NOK consent to referral? Yes / No
We are a non-smoking Hospital and do not tolerate aggressive or violent behaviour ☐

Clinician Name: **Signature:** **Designation:** **Date:**

Page 2 must be completed, please turn over

PATIENT NAME: **DOB:** **UR NO:**

NURSING:

Print Name: Signature: Designation: Date:

LEVEL OF ASSISTANCE REQUIRED FOR DAILY ACTIVITIES **√ appropriate level**

	Total Assistance	Maximal Assistance	Moderate Assistance	Minimal Assistance	Supervision	Modified Independence	Complete Independence
Eating							
Grooming							
Bathing							
Dressing – Upper							
Dressing – Lower							
Toileting							
Bladder Management							
Bowel Management							
TRANSFERS							
Bed/Chair/Wheelchair							
Toilet							
Bath/shower							
LOCOMOTION							
Walk/wheelchair							
Stairs							

ALLIED HEALTH:

Print Name: Signature: Designation: Date:

SOCIAL WORK:

Print Name: Signature: Designation: Date: