wdhs Western District Health Service

WDHS Sub-Acute Referral

Enquiries / Referrals to: teamleader.subacute@wdhs.net T: (03) 5551 8254 F: (03) 5551 8572

Please note all questions marked with * are required fields.

REFERRING FACILITY

Referring facility*

Name of referring consultant*

Position held*

Current ward*

Current ward telephone no.*

PREFERRED CONTACT DETAILS

Name of hospital contact*

Email*

Phone*

Mobile*

PATIENT DETAILS

Surname of patient*

Given name/s*

Date of birth*

Age*

Weight*

Gender*

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PATIENT DETAILS CONT.

Address*

Marital status

Patient preferred phone number

Religion

Date of first hospital admission*

Date admitted to referring facility*

Current admission diagnosis*

Operative date, if applicable

Past medical history *

REHABILITATION

Type of rehabilitation required*

Rehabilitation goals *

RESIDENTIAL DETAILS

Lives with*

Other

DIET

Diet * FWD PEG NGT DIABETIC

Texture * SOFT CUT UP MINCED PUREE

PREMORBID FUNCTION

Please indicate with I, A or D

Indoor mobility*	I (Independent)	A (Assist)	D (Dependent)
Transfers*	I (Independent)	A (Assist)	D (Dependent)
Personal care*	I (Independent)	A (Assist)	D (Dependent)
Continent urine *	Yes	No	
Continent faeces *	Yes	No	

Equipment, gait, aid required by patient (prior to recent problems) *

CURRENT FUNCTION

Please indicate with I, A or D

Indoor mobility *	I (Independent)	A (Assist)	D (Dependent)
Transfers *	I (Independent)	A (Assist)	D (Dependent)
Personal care *	I (Independent)	A (Assist)	D (Dependent)
Continent urine *	Yes	No	
Continent faeces *	Yes	No	

Please outline current equipment, gait ait currently required by patient *

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CURRENT COGNITION

Has additional staffing been required? *	Yes	No
Has there been any formalised cognitive testing? *	Yes	No
Alert *	Yes	No
Orientation *	Yes	No
Does the patient have short term memory loss? *	Yes	No

Is the current cognitive function stable? *

Other:

CURRENT BEHAVIOUR/MOOD

No issues *	Yes	No
Uncooperative *	Yes	No
Disruptive *	Yes	No
Aggressive *	Yes	No
Depressed *	Yes	No

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CURRENT BEHAVIOUR MOOD cont.

Anxious *	Yes	No
Has additional staffing been required? *	Yes	No
Wanders *	Yes	No
Other		

REFERRAL CONSENT

Has referral been consented by the patient / representative? *	Yes	No

PAYMENT RESPONSIBILITY

Payment type:

Other:

Payment type number

Please note if SUBMIT button does not work. Save this document with your changes and contact the team using the details below.

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