Buderim Private Hospital

PATIENT LABEL

Family Name:

Given Name:

Address:

Phone: DOB:

Health Fund: Member No:

Please Tick: ☐ **Inpatient** ☐ **Day Program**

REFERRAL REQUEST FOR REHABILITATION SERVICES

Date of Referral: / / Doctor Referring: Doctor Signature:

Provider Number: GP Name:

Diagnosis: Date of Surgery:

Relevant Medical Issues:

Social Situation: ☐ Lives alone ☐ Carer ☐ Care Facility ☐ Low care ☐ High Care

☐ Other:

CURRENT FUNCTIONAL STATUS

Cognition: ☐ Alert ☐ Confusion ☐ Short Term Memory Loss ☐ Depression ☐ Dementia

Weight-bearing status:

Pressure injury ☐ Yes ☐ No If yes, location and stage

Falls risk ☐ High ☐ Medium ☐ Low

Swallow: ☐ Normal ☐ Impaired

Diet: ☐ Normal ☐ Soft ☐ Minced ☐ Pureed ☐ Diabetic ☐ HPHE

Fluids: ☐ Normal ☐ Mildly Thick ☐ Moderately Thick ☐ Extremely Thick

	2 Person	1 Person	Supervise/ Setup	Independent	Equipment/Aid	Comment
Transfers						
Toileting						
Showering						
Dressing						
Mobility						
Eating						
Continence						

Infection Control: ☐ MRSA ☐ VRE ☐ ESBL ☐ Other:

General Comment/ Special Needs:

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Reviewed by: ☐ Dr Fialla ☐ Dr Eckerman Rehabilitation goals ☐ Yes ☐ No

☐ Accepted ☐ Declined For day rehabilitation: ☐ PT ☐ OT ☐ EP ☐ Other

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