Eastern Suburbs Private Hospital

REHABILITATION PRE-ADMISSION FORM

FAX: (02) 9398 8472
EMAIL: administration@mhseastern.com.au

To be completed by:
Specialist, GP or Discharge Planner
(Please PRINT clearly)

Attach Patient Sticker Here

PROGRAM TYPE

❑ **Orthopaedic** ❑ **Neurological** ❑ **Reconditioning** ❑ **Other:**

PATIENT DETAILS

Title: ..... Given Names: ..... Surname: .....

Address: .....

Mobile: ..... Phone (H): ..... Date of Birth: ..... ❑ M ❑ F Weight: (kg) .....

Person Responsible: ..... R'Ship: ..... Contact No: .....

GP Name: ..... Contact No: .....

Medicare: ..... Ref No: ..... Exp.Date: ..... Pension No: ..... PBS No: .....

Health Fund/DVA/Insurance Name: ..... Membership/DVA No: .....

Schedule: ..... *Excess:* $ ..... *Co-Payment* $ .....

Usual Living Arrangements: ❑ Own Home ❑ Rents ❑ Hostel ❑ Nursing Home
Lives: ❑ Alone ❑ W/Partner ❑ W/Relatives ❑ W/Carer

CLINICAL DETAILS *On transfer please provide copies of medication charts, dopplers, bloods and any scans*

Reason For Referral: .....

Recent ACAT Assessment: ❑ No ❑ Yes *Details:* .....

Allergies: .....

Anti-Coagulants: ❑ No ❑ Yes ..... Medications Coming With Patient: ❑ No ❑ Yes

Cardiopulmonary Status: ..... Requires $O^{2:}$ ❑ No ❑ Yes

MRSA Swabs: ❑ Nose (+ve / -ve) ❑ Axillia (+ve / -ve) ❑ Groin (+ve / -ve) ❑ Wound (+ve / -ve)
VRE History: ❑ No ❑ Yes MRSA History:: ❑ No ❑ Yes
Risk Of Pressure Injury: ❑ No ❑ Yes Wound Management ❑ No ❑ Yes

Skin Integrity *(bruises, decubitus, ulcers, wounds):* .....

Falls Risk: .....

Mobility: *Assistance* ❑ Independent ❑ Supervision+A ❑ Assist x 1 ❑ Assist x 2
Aide ❑ Nil ❑ FASF ❑ 4WW ❑ 2WW ❑ Stick/s ❑ Crutches ❑ W/Chair

Weight Bearing: ❑ N/A ❑ Partial ❑ Touch ❑ WBAT ❑ NWB *(weeks)*: .....

Cognitive: ❑ Intact ❑ Confusion ❑ Delirium ❑ Dementia

Continence: *Bladder* ❑ Continent ❑ Incontinent ❑ IDC
Bowel ❑ Continent ❑ Incontinent ❑ Colostomy

Personal Care: ❑ Independent ❑ Requires Assistance ❑ Fully Dependent

Hydrotherapy: ❑ No ❑ Yes *date to commence* .....

Swallowing Intact: ❑ Yes ❑ No ❑ NGT / PEG

Diet: ❑ Normal ❑ Diabetic ❑ Tube Feed ❑ Supplement:

DOES THE PATIENT HAVE AN ADVANCED CARE DIRECTIVE ❑ **No** ❑ **Yes**

TRANSFERRING FACILITY DETAILS

Facility Name: ..... Ward: ..... Date Admitted: .....

Contact Person: ..... Phone: ..... Expected Transfer Date: .....

Discharge Destination ❑ Home ❑ Aged Care Facility ❑ Transitional Care ❑ With: .....

REFERRER'S DETAILS

Referrer's Name: ..... Signature: .....

Provider No: ..... Date: .....

PATIENT AGREEMENT

Patient Signature: ..... Date: .....