South Gippsland Hospital

SGH Inpatient Services Referral Form 1109

Name:
Address:
Phone:
D.O.B: **Sex:** Male/Female
MRN:
GP:

Affix Bradma Label Here

Referral to: Health Service: **South Gippsland Hospital**

Bed Type *(i.e. Acute, Rehab, GEM)*:

Referrer Details

Organisation: Date of Referral:

Unit: Contact Person:

Phone: Fax: Alternate Contact Number:

Reason for Referral:

Name, Designation of Referrer: Date:

Patient's Medical Details at Referral

Anticipated date of transfer: Date of Acute Onset:

Diagnosis / Medical Notes or Presenting illness:

Any Ongoing Acute Medical Issues:

Past Medical / Psych History:

Allergies/Adverse Drug Reactions:

Consent

Does the patient consent to referral?

☐ Yes ☐ No If no, why?

Infections

Does the patient have any infectious risks?

☐ MRSA ☐ VRE ☐ CPE ☐ Other, Specify

Patient Details

Name of NOK:
Relationship:
Telephone:
Contact (If different from NOK)
Relationship:

Guardian / Administrator

Power of Attorney ☐ Yes ☐ No
Details:
Case Manager:
Care Package Type:
☐ Work Cover No:

Telephone: ..... | Private Health ☐ Yes ☐ No

Patient Goals and Expectations:

.....

.....

.....

.....

Name: _____

Address: _____

Phone: _____ **DOB:** _____

MRN: _____ **Sex:** _____

GP:

Affix bradma label here

Advanced Care Planning

Does the patient have an Advanced Care Directive?

☐ Yes ☐ No Details: .....

Anticipated Discharge Destination Post Inpatient Rehabilitation / GEM

☐ Home ☐ Other .....

☐ ACAS assessment – Date: ..... Residential Care: ☐ Low Level ☐ High Level

Social / Family Supports

Lives:

☐ Alone ☐ Family ☐ Other: .....

☐ House ☐ Flat / Unit ☐ Aged Care Facility ☐ Other .....

Previous Services Received:

☐ MOW ☐ Home Care ☐ District Nursing ☐ Other: .....

Please comment on patient's level of function prior to this event (i.e. ADLs, mobility etc.):

.....

.....

Current Physical Function

Weight Bearing Status

☐ Non WB ☐ Touch WB ☐ Partial WB ☐ WB as tolerated ☐ Full WB

Falls Risk: ☐ High ☐ Medium ☐ Low **Recent Falls:** .....

High Risk Strategies (i.e. Exit Alarm, Visual Observations)

Mobility / Transfers: ☐ Independent ☐ Supervision ☐ Assist ☐ Dependent

Aids: ..... Endurance: .....

Own Equipment: ☐ Yes ☐ No

Activities of Daily Living ☐ Independent ☐ Supervision ☐ Assist ☐ Dependent

Other Physical Issues: .....

.....

Nutrition / Diet

Weight: ..... Date: .....

Dietary Requirements: ☐ Full Ward Diet ☐ Modified Diet ☐ Enteral Feeding ☐ Other

Details: .....

Communication

Are there any communication difficulties? ☐ No ☐ Yes

Details: .....

Is English the patient's first language? ☐ No ☐ Yes

If no, what is their main language: .....

Is an interpreter required? ☐ No ☐ Yes

Name: _____

Address: _____

Phone: _____

DOB: _____

MRN: _____ **Sex:** Male/Female

GP:

Is the client: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander ☐ Neither

Cognition / Behaviour *Are there any Cognitive Concerns:* ☐ No ☐ Yes

Are there any Behavioural Concerns: ☐ No ☐ Yes

Details: .....

Does patient exhibit any withdrawal symptoms: ☐ No ☐ Yes Details: .....

Does the patient require Visual Observations / Bed Alarm: ☐ No ☐ Yes Details: .....

Cognitive Assessment: ..... Score: ..... Date: ..... Report Attached ☐

Neuropsychiatric Cognitive Assessment (NUCOG) Score: ..... Date: ..... Report Attached ☐

Elimination Bladder: ☐ Continent ☐ Incontinent ☐ Catheter ☐ Other .....

Bowels: ☐ Continent ☐ Incontinent ☐ Stoma ☐ Other .....

Continence Aids used: .....

Skin Integrity / Wounds

Location: ..... Aetiology: ..... Duration: .....

☐ Acute ☐ Chronic Pressure Area Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A

Further Details: ..... Report Attached ☐

Medications

List of current medications and recent medication changes: (*Attaching copy of current drug chart and Medication Reconciliation Form / Medication Management Plan will suffice*)

.....

.....

Special Treatment and Equipment Needs *(Please provide details)*

☐ Dialysis ..... ☐ IV Therapy / Antibiotics .....

☐ Bariatric ..... ☐ Oxygen .....

☐ Other (Braces, Splints, orthosis, prosthesis, pressure equipment) .....

.....

Follow Up Tests / Appointments

Date	Time	Test / Appointment	Location

IMPORTANT - Please ensure that all relevant supporting documents are attached to the referral
(Allied Health Assessments, Medication Chart / Reconciliation Form, Recent Pathology, Discharge Summary etc.)

Date Referral Received: ..... Date of Acceptance (if applicable): .....

Outcome of Referral: .....

.....

Name & Designation: ..... Signed: .....

MRN:	**Name:**	**DOB:**

OFFICE USE ONLY: