

SGH Acute Inpatient Services Referral Form 1109

Instructions for completing form

- In order to expedite acceptance of your referrals SGH requests that all sections and pages of referral form is completed all supporting documentation is provided to enable a swift and informed response.
- Please send referral form and all supporting documentation by either fax: **5683 9745** or email: **SGH.Coordinator@sghs.com.au**. Then call the Nurse in Charge or After-Hours Coordinator on **5683 9701** to discuss patient.
 - Once patient has been accepted by the Nurse in Charge or After-Hours Coordinator a medical handover will also be required to the Doctor on call for the day.
- **Once Doctor on call accepts patient and bed available, transport can be booked.**
 - On day of transfer a nurse-to-nurse handover is also requested.

Please note SGH:

1. Does not have rehabilitation/GEM beds.
2. Does **not** have onsite **security**.
3. Preferable for transfers to arrive before 1800hrs as Doctor not on site 24hrs a day.
4. Limited radiology services (business hours Monday-Friday).
5. No onsite Pathology Lab.
6. No onsite Pharmacy.
7. BMI Admission Capability: 35-40 must be able to mobilise with minimal assistance, > 40 needs approval by DON.

Please Contact the Nurse in Charge or the After-Hours Coordinator with any questions regarding the referral process.



SGH Acute Inpatient Services Referral - Form 1109

Name: _____
Address: _____

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

Affix Bradma Label Here

Referrer Details

Organisation: _____ Date of Referral: _____
 Unit: _____ Contact Person: _____
 Phone: _____ Fax: _____
 Reason for Referral: _____

 Name, Designation of Referrer: _____ Date: _____

Patient's Medical Details at Referral

Anticipated date of transfer: _____ Usual GP: _____
 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 van A VRE van B ESBL COVID Candida Auris
 CPE If Yes: Is the patient currently in a Transmission Risk Area? Yes / No
 Has the patient been screened and cleared? Yes / No
 Other: _____

<p>Patient Details</p> <p>Name of NOK: _____ Relationship: _____ Telephone: _____ Contact (If different from NOK) _____ Relationship: _____ Telephone: _____</p>	<p>Guardian / Administrator</p> <p>Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____ Case Manager: _____ Care Package Type: _____ <input type="checkbox"/> Work Cover No: _____ Private Health <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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SGH Acute Inpatient Services

Name: _____
Address: _____

Phone: _____
D.O.B: _____ **Sex:** Male/Female
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Patient Goals and Expectations:

Referral - Form 1109

IV Access

IVC PICC PORT CVC
 Location: _____
 Date of Insertion: _____
 Change Due: _____

Advanced Care Planning

Does the patient have an Advanced Care Directive?
 Yes No Details: _____

Anticipated Discharge Destination

Home RACF Other _____
 ACAS assessment Yes No
 Outcome: _____

Social / Family Supports

Lives:
 Alone Family Other: _____
 House Flat / Unit Aged Care Facility Other _____
Previous Services Received:
 MOW Home Care District Nursing Other: _____

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: _____



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Name: _____
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Phone: _____
D.O.B: _____ **Sex:** Male/Female
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Nutrition / Diet
 Weight: _____ Date: _____
 Dietary Requirements: Full Ward Diet Modified Diet Enteral Feeding Other
 Details: _____

Communication:
 Are there any communication difficulties? No Yes
 Details: _____
 What is the patient's first language? _____
 Is an interpreter required? No Yes
 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 Behaviours of Concern? 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: _____ GCS: _____ Date: _____ Delirium Screen Attached

Elimination Bladder: Continent Incontinent Catheter Other _____
 Bowels: Continent Incontinent Stoma Other _____
 Contenance Aids used: _____

Skin Integrity / Wounds
 Location: _____ Aetiology: _____ Duration: _____
 Acute Chronic Pressure Area Stage: _____
 Further Details: _____ Wound Chart Attached

Medications:
 Please attach copy of current medication chart, with note of any recent medication changes.



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Address:	_____ _____
Phone:	_____
D.O.B:	_____ Sex: Male/Female
MRN:	_____
GP:	_____
Affix Bradma Label Here	

Follow Up Tests / Appointments

Date	Time	Test / Appointment	Location

IMPORTANT – Please attach any supporting documentation to referral.

Medical Summary/Discharge letter

Allied Health Assessments

Medication Chart

Recent Pathology & Radiology

Date Referral Received: _____	Date of Acceptance (if applicable): _____
Outcome of Referral: _____ _____	
Name & Designation: _____	Signed: _____

Office Use Only: