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.

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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 ☐ CPE ☐ ESBL ☐ COVID ☐
Other: ______

Patient Details

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

Guardian / Administrator

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

Name: ______
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______
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Patient Goals and Expectations:

______
______
______

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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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 ....

Continence 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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____
Phone: ______________________
D.O.B: ______________ **Sex:** Male/Female
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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: