South Gippsland Hospital

MR1109

SGH Inpatient Services Referral

Surname:.....

Given Names:.....

Date of Birth:.....Gender:.....

UR No.:.....

(AFFIX PATIENT LABEL HERE)

FOLLOW UP TESTS / APPOINTMENTS			
Date	**Time**	**Test / Appointment**	**Location**

IMPORTANT – Please attach 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:

Signature: Date:

Name/Designation: Time:

SGH INPATIENT SERVICES REFERRAL MR1109

Paper form – Scan to EMR

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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.

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 of Presenting Illness:	
Any Ongoing Acute Medical Issues:	
Past Medical / Psych History:	
Allergies / Adverse Drug Reaction:	

CONSENT
Does the patient consent to referral? ☐ Yes ☐ No, if no why?

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INFECTIONS

Does the patient have any infectious risks? ☐ Yes ☐ No

☐ 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:

PATIENT DETAILS	GUARDIAN / ADMINISTRATOR
Name of NOK:	**Power of Attorney:** ☐ Yes ☐ No
Relationship:	Details:
Telephone:	Case Manager:
Contact: (If different from NOK)	Care Package Type:
Relationship:	☐ Work cover No.:
Telephone:	Private Health: ☐ Yes ☐ No

Patient Goals & 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:

Signature: Date:

Name/Designation: Time:

SGH INPATIENT SERVICES REFERRAL MR1109

SGHSO2733

MR1109 – v5 10_2025

Paper form – Scan to EMR

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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? ☐ Yes ☐ No

Details:

What is the patient's first language? Is an interpreter required? ☐ Yes ☐ No

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

COGNITION / BEHAVIOUR

Are there any Cognition Concerns? ☐ No ☐ Yes, *details*:

Are there any Behaviour Concerns? ☐ No ☐ Yes, *details*:

Does the 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 ☐ Catheter ☐ Other:

Continence aids used:

SKIN INTEGRITY / WOUNDS

Location: Aetiology: Duration:

☐ Acute ☐ Chronic ☐ Pressure Area State:

Further details: ☐ Wound Chart Attached

MEDICATIONS

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

Signature: Date:

Name/Designation: Time:

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A3L-BOTH SIDES FLIP SHORT EDGE