Peninsula Health
Community & Continuing Care

# EXTERNAL REFERRAL FOR SUB ACUTE ADMISSION

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....
Please fill in if no Patient Label available

App.22/2/2024 Print Code:14443

PHF553700T

***Subacute Assessment Service:*** *Phone: 9784 8197 Fax: 9125 8982 Email address: saasadmissions@phcn.vic.gov.au*

Referral for: ☐ Inpatient Rehabilitation ☐ Geriatric Evaluation & Management

☐ Private Health Insurance Details ..... ☐ Work cover ☐ TAC ☐ DVA ☐ Not insured

Referring Hospital ..... Ward..... NUM..... Contact.....

Social Situation ☐ Lives Alone ☐ Lives with ..... ☐ Provides care for another person

☐ Home ☐ Supported Residential Service ☐ Residential Care ☐ Other .....

**Next of Kin:**

1. Name ..... Phone No. .....

2. Name ..... Phone No. .....

Do the patient / carer have an understanding about the reason for admission to sub acute care? ☐ Yes ☐ No

Comments .....

Interpreter required ☐ No ☐ Yes - Language required .....

| Presenting Problems / Diagnosis / Surgery details | Past History |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Medications of Significance**: Please fax current Medication Chart

☐ Anticonvulsants ☐ Insulin ☐ Narcotic Analgesia ☐ Warfarin ☐ Heparin ☐ Clexane ☐ Prednisolone ☐ Antipsychotic

Current Pathology faxed with referral ☐ Yes ☐ No

| Investigations: | Faxed: |
|---|---|
| ☐ Xray | ☐ |
| ☐ ECG | ☐ |
| ☐ EEG | ☐ |
| ☐ CT | ☐ |
| ☐ U/S | ☐ |
| ☐ MRI | ☐ |
| ☐ Doppler | ☐ |
| ☐ Other | ☐ |

**Specific Care needs for consideration:**

| | | |
|---|---|---|
| ☐ Skin Integrity | ☐ Wound | ☐ Weight Bearing Status |
| ☐ Oxygen Therapy | ☐ NFR | ☐ Falls Risk |
| ☐ Infection Control | ☐ PICC Line | ☐ Wandering Behaviours |
| ☐ PEG Feeds | ☐ BSL | ☐ Bariatric Weight .....kg |
| ☐ Behaviours of Concern | | ☐ Girth .....cms |

Specify special equipment required / comments

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Comments / Other Issues

Follow up Appointments

EXTERNAL REFERRAL FOR SUB ACUTE ADMISSION

MR/553700

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# EXTERNAL REFERRAL FOR SUB ACUTE ADMISSION cont.

UR NUMBER .....

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GIVEN NAMES .....

DATE OF BIRTH .....
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PHF5537007T

| | Previous Level of Function | Current Level of Function |
|---|---|---|
| Mobility | | |
| Transfers - bed/chair/toilet | | |
| Continence | | |
| Hygiene | | |
| Dressing | | |
| Eating / Nutrition | | |
| Communication | | |
| Cognition | | |
| Vision | | |
| Hearing | | |

| Problem List | Plan / Goals |
|---|---|
| ☐ Changes to mobility | **Goals to be achieved in Sub-Acute setting:** |
| Specify ..... | ☐ Optimise mobility and function |
| ☐ Dependence on Mobility Aids | ☐ Pain management |
| ☐ Difficulty with transfers | ☐ Cognitive Assessment |
| ☐ Falls | ☐ Assess appropriate discharge destination |
| ☐ Assist with personal hygiene, dressing and grooming | **Anticipated Discharge Destination:** |
| ☐ Cognitive decline ☐ Acute ☐ Chronic | ☐ Home |
| ☐ Pain | ☐ Supported Residential Care |
| ☐ Bariatric | ☐ Residential Care |
| ☐ Surgical wound | ☐ Other ..... |
| ☐ Other ..... | ..... |

**OBSERVATIONS** - fax Observations Chart

BP ...../..... HR ..... RR ..... SaO2 ..... O2 req ..... T .....

Vital signs are normal and have been stable for 24 hours ☐ Yes ☐ No

Medically stable ☐ Yes ☐ No

Significant change to medication has occurred in the past 24 hours ☐ No ☐ Yes .....

The patient will require medical review in the next 24 hours ☐ No ☐ Yes .....

Patient / NOK site preference ☐ GLR ☐ TMC ☐ RRU

Estimated Length of Stay: ☐ 5 - 7 days ☐ 1 - 2 weeks ☐ 2 - 3 weeks ☐ 3 - 4 weeks

☐ Over 4 weeks - Specify .....

☐ Clinical Issues Summary letter provided by Rehabilitation Consultant / Geriatrician / treating Doctor

☐ Clinical Assessments provided by Allied Health

| ..... | ..... | ..... | ..... |
|---|---|---|---|
| Signature | Print Name | Designation | Date / Time |