

**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

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

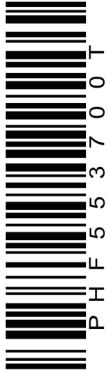
**Medications of Significance:** Please fax current Medication Chart

Anticonvulsants  Insulin  Narcotic Analgesia  Warfarin  Heparin  Clexane  Prednisolone  Antipsychotic  
Current Pathology faxed with referral  Yes  No

Investigations:	Faxed:	Specific Care needs for consideration:
<input type="checkbox"/> Xray	<input type="checkbox"/>	<input type="checkbox"/> Skin Integrity <input type="checkbox"/> Wound <input type="checkbox"/> Weight Bearing Status
<input type="checkbox"/> ECG	<input type="checkbox"/>	<input type="checkbox"/> Oxygen Therapy <input type="checkbox"/> NFR <input type="checkbox"/> Falls Risk
<input type="checkbox"/> EEG	<input type="checkbox"/>	<input type="checkbox"/> Infection Control <input type="checkbox"/> PICC Line <input type="checkbox"/> Wandering Behaviours
<input type="checkbox"/> CT	<input type="checkbox"/>	<input type="checkbox"/> PEG Feeds <input type="checkbox"/> BSL <input type="checkbox"/> Bariatric Weight .....kg
<input type="checkbox"/> U/S	<input type="checkbox"/>	<input type="checkbox"/> Behaviours of Concern <input type="checkbox"/> Girth .....cms
<input type="checkbox"/> MRI	<input type="checkbox"/>	Specify special equipment required / comments
<input type="checkbox"/> Doppler	<input type="checkbox"/>	.....
<input type="checkbox"/> Other	<input type="checkbox"/>	.....

Comments / Other Issues

Follow up Appointments



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	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
<input type="checkbox"/> Changes to mobility Specify ..... <input type="checkbox"/> Dependence on Mobility Aids <input type="checkbox"/> Difficulty with transfers <input type="checkbox"/> Falls <input type="checkbox"/> Assist with personal hygiene, dressing and grooming <input type="checkbox"/> Cognitive decline <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Pain <input type="checkbox"/> Bariatric <input type="checkbox"/> Surgical wound <input type="checkbox"/> Other .....	<p><b>Goals to be achieved in Sub-Acute setting:</b></p> <input type="checkbox"/> Optimise mobility and function <input type="checkbox"/> Pain management <input type="checkbox"/> Cognitive Assessment <input type="checkbox"/> Assess appropriate discharge destination
	<p><b>Anticipated Discharge Destination:</b></p> <input type="checkbox"/> Home <input type="checkbox"/> Supported Residential Care <input type="checkbox"/> Residential Care <input type="checkbox"/> 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