UnitingCare Health

The Wesley HOSPITAL
Caring for you for life

Family Name: ____________________ MR/UR: ______________
Given names: ____
Address: ____
Postcode: ______________ DOB: _______________________
Doctor: ____
(or place Patient Identification Label here)

Rehabilitation Referral Request

REFERRAL TO: DR ____________________ **GENERAL PRACTITIONER** ____________________
DATE OF REFERRAL ____________________ **DIAGNOSIS** ____________________
DOCTOR REFERRING ____________________ ____________________

ALLERGIES: ____________________
RELEVANT MEDICAL ISSUES: ____________________

PREVIOUS FUNCTIONAL STATUS:

Social Situation: ☐ Lives alone ☐ Carer ☐ Care Facility ☐ Low Care ☐ High Care ☐ Other: ____________
Cognition: ☐ Alert ☐ Confusion ☐ Short Term Memory Loss ☐ Depression
Communication: ☐ Normal ☐ Other: ____________ **Swallow:** ☐ Normal ☐ Impaired
Diet: ☐ Normal ☐ Soft ☐ Minced ☐ Pureed
Fluids: ☐ Normal ☐ Mildly thick ☐ Moderately thick ☐ Extremely thick

LEVEL OF DEPENDENCE

	2 person	1 person	Supervise / Setup	Independent	Equipment / Aid	Comment
Transfers						
Toileting						
Showering						
Dressing						
Mobility						
Eating						
Continence						

GENERAL COMMENTS / SPECIAL NEEDS: ____________________

DISCHARGE TO: ____________________ **TRANSPORT:** ☐ QAS Other: ____________________

HEALTH PROFESSIONAL COMPLETING REFERRAL: ____________________ **DATE:** ____ / ____ / ____

SIGNATURE: ____________________ **CONTACT NO.** ____________________

THE WESLEY HOSPITAL
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Email referral to inpatient rehabilitation Clinical Nurse Manager (CNM) (Annette.Will@uchealth.com.au) and the rehabilitation ward email (TWH.ward1K@uchealth.com.au).