MetroRehab
HOSPITAL

# INPATIENT REFERRAL FORM

Please fax to 9564 3064

275 Addison Road, Petersham NSW 2049
**Phone:** 02 9569 5622 - **Mobile:** 0417 200 128
www.metrorehab.com.au

## 1. PATIENT DETAILS:



Patient's Name:.....DOB:.....Age:.....

Sex: ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ W ☐ D ☐ Single Room Requested

Descent: ☐ Aboriginal ☐ Torres Strait Islander

Address: .....

Telephone: ..... Religion:.....Country of Birth:.....

Next of Kin:.....Relationship:.....

Address: .....Telephone: (H).....(M).....

## 2. REFERRAL DETAILS

Date of Referral: .....Referring from: ☐ Home ☐ Hospital:.....Ward:.....

Person Referring:..... Telephone:..... Provider No:.....

Date of Original Hospital Admission:..... Referring Specialist:.....

Specialist Room's Address: ..... Telephone:.....

GP: ..... Telephone:.....

GP Address: .....

Previous Patient at Metro: Yes / No **EXPECTED DATE OF ADMISSION TO METRO REHAB:** .....

## 3. FUND DETAILS:

Medicare No:.....Expiry Date:.....Pension No:.....

Private Health Fund:.....Membership No:.....

Is this injury the result of an insurable accident? ☐ Yes ☐ No

WC/CTP Insurance Company: .....Claim No:.....

Case Manager: ..... Tel:.....Fax:.....

## 4. CLINICAL DETAILS:

**Diagnosis/Operation:** ..... Op Date:.....

**Relevant Medical History:**.....

.....

**Current Medications:**.....

**Allergies:**..... Nil known: ☐

**Medical:** ☐ O2 **Gastro Symptoms:** ☐ Yes ☐ No **Flu Symptoms:** ☐ Yes ☐ No

**Multi Resistant Organisms:** ☐ Nil ☐ VRE ☐ MRSA ☐ ESBL Site: .....

**Cognitive Status:** ☐ Alert ☐ Orientated ☐ Cooperative ☐ Dementia ☐ Delirium ☐ Night Confusion

**Mobility/Transfers:** ☐ Independent ☐ Assist.....person(s) min/mod/max **Aid:**..... ☐ Hoist

**Weight Bearing Status:** ☐ FWB / WBAT ☐ PWB ☐ TWB ☐ NWB (for.....more weeks)

**ADL's:** ☐ Independent ☐ Supervision ☐ Min Assist ☐ Mod Assist ☐ Full Assist

**Continence:** ☐ Continent ☐ Incontinent Bowels ☐ Incontinent Bladder ☐ IDC ☐ SPC ☐ Colostomy

**Nutrition:** ☐ Diabetic ☐ NGT ☐ PEG Diet:..... Supplements:.....

**Skin Integrity:** Wound: ☐ Yes ☐ No Pressure Area: ☐ Yes ☐ No Grade: .....

Location:.....Dressing:.....

**Weight:**.....kgs **Specialised Equipment Required:** .....

BINDING MARGIN — DO NOT WRITE

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FM Pat NSG-01 (03.12)