ST JOHN OF GOD
Mt Lawley Hospital

REFERRAL FORM
SPECIALIST REHABILITATION SERVICES

Email: srsreferrals@sjog.org.au

MT LAWLEY USE ONLY

Nurse Handover:

Accepting Dr:

ETA/Bed:

Name:

DOB:

URN:

Does the patient identify as Aboriginal and/or Torres Strait Islander? ☐ Yes ☐ No

Medicare No:

Medicare Expiry Date:

Health Fund:

Fund Level:

Member number:

Is there a Guardianship order in place? ☐ Yes ☐ No

Guardian Name:

Contact Number:

Is there an Administrator order in place? ☐ Yes ☐ No

Administrator Name:

Contact Number:

Is there an Enduring Power of Attorney? ☐ Yes ☐ No

Enduring Power of Attorney Name:

Contact Number:

Is there an Enduring Power of Guardianship? ☐ Yes ☐ No

Enduring Power of Guardianship Name:

Contact Number:

Date of Referral:

Current Ward:

Referring Dr:

Current Hospital:

Diagnosis/Complications during stay:

Medical Hx:

Rehab Goals:

COGNITION

☐ Alert	☐ Orientated	☐ Confused
☐ Companion	☐ Delirium	

RESPIRATORY FUNCTION

☐ N/A	☐ O_2	L/min:
☐ Home O_2	☐ Cpap	☐ Bipap

INFECTION RISK

☐ N/A	Type:	
☐ Isolated	☐ IVABs	☐ Long term ID involvement

MOBILITY

☐ Independent	☐ SBA	☐ 1A
☐ 2A	☐ 2-3A	
☐ WZF	☐ SS	☐ Hoist

ORTHO/SPINAL

☐ N/A	☐ WBAT	☐ TWB
☐ NWB	☐ Brace/Sling/Collar	Type:

DIET

☐ N/A	☐ PEG	☐ NGT	☐ Dysphagia

WEIGHT CRITERIA

☐ N/A	☐ Bariatric	☐ < 160kgs	☐ Girth < 68cm

CONTINENCE

☐ N/A	☐ IDC	☐ Stoma	☐ Long term

WOUND

☐ N/A	☐ Simple wound	☐ Complex	☐ Drain

SOCIAL HX

POSSIBLE OUTCOME

☐ Home	☐ TCP	☐ RACF
☐ Palliative	☐ Discussed with PT	☐ Discussed with family

Other: