

PATIENT DETAILS

Title _____ Surname _____ Ph/Mob. _____
Given Names _____ Email _____
Address _____ Medicare No. _____ CALD ATSI
_____ State _____ Postcode _____
Next of Kin _____
Date of Birth _____ Relationship _____ Ph. _____
Referring Doctor _____ Ph. _____ GP _____ Ph. _____
Specialist _____ Ph. _____ Specialty _____
Hospital _____ Admission Date _____ Discharge Date _____ UR No. _____
Ward _____ Inpatient Rehab Admission Yes No

FUNDING

Health Fund _____ Membership No. _____ DRG _____ HT _____
 Self Funded _____ DVA _____ Aged Care (HCP) _____
 Hospital Funded _____ Visit No _____ Other _____
 Workers Compensation/Third Party: Provider _____ Claim No. _____
Case Manager _____ Ph. _____

HEALTH DETAILS

Primary Diagnosis _____
Surgical Procedure (if applicable) _____ Date _____
Co-morbidities _____

Past History _____
Allergies _____
Infection control alerts: Hep B or C HIV MRSA VRE Other MRO (specify) _____ Wound Swab pending

SERVICES REQUIRED

HITH Rehab - Joint Rehab - No Gap Orthopaedics Rehab - Other Palliative Care
 Chronic Disease Aged Care Other _____

ISSUES REQUIRING MANAGEMENT

Medication _____
 Wound _____

 Pain _____
 Cognitive _____ Behavioural _____
 Other _____ Diabetes: Type I Type II
 Continence _____ Mental Health _____
 Falls Risk _____

ATTACHMENTS

(where relevant) Discharge Summary Medication Authority Scripts Wound Chart Allied Health Report Advanced Directive

ADDITIONAL INFORMATION

Preferred Physio Provider _____ Phone _____
Subsequent Pharmacy _____ Commencement Date _____

Referrer Name _____ Email _____ Signature _____

Position _____ Ph. _____ Provider No. _____ Date _____