Eastern Suburbs Private Hospital

REHABILITATION PRE-ADMISSION FORM

FAX: (02) 9398 8472
EMAIL: esphenquiries@machealth.com.au
To be completed by:
Specialist, GP or Discharge Planner
(Please PRINT clearly)

Attach Patient Sticker Here

PROGRAM TYPE

☐ **Orthopaedic** ☐ **Neurological** ☐ **Reconditioning** ☐ **Other:** _____

PATIENT DETAILS

Title: _____ Given names: _____ Surname: _____

Address: _____

Mobile: Person responsible: _____ Phone(H): _____ Date of birth: _____ ○ Male ○ Female

GP Name: _____ Relationship: _____ Contact No: _____

Medicare: _____ Contact No: _____

Health Fund/DVA/Insurance Name: _____ Ref No: _____ Exp.Date: _____ Pension No: _____ PBS No: _____

Schedule: _____ Membership/DVA No: _____

Usual Living Arrangements: _____ Excess: $ _____ Co-Payment: $ _____

ABTSI culture: ☐ Alone ☐ W/Partner ☐ W/Relatives ☐ W/Carer ☐ Hostel ☐ Nursing Home

CLINICAL DETAILS –On transfer please provide copies of medication charts, dopplers, bloods and any scans

Diagnosis: _____

Recent ACAT Assessment: ☐ No ☐ Yes Details: _____

Allergies: _____

Anti-Coagulants: ☐ No ☐ Yes Medications Coming With Patient: ☐ No ☐ Yes

Cardiopulmonary Status: _____ Requires O^2: ☐ No ☐ Yes

MRSA Swabs: ☐ Nose (+ve/ -ve) ☐ Axillia(+ve/ -ve) ☐ Groin (+ve/ -ve) ☐ Wound (+ve/ -ve)

VRE History: ☐ No ☐ Yes MRSA History: ☐ No ☐ Yes

COVID test: ☐ No ☐ Yes Result (+ve/ -ve) _____ Any Symptoms: _____

Wound / Pressure Injury: _____ WaterlowScore: _____

Swallowing Intact: ☐ Yes ☐ No ☐ NGT / PEG

Diet: ☐ Normal ☐ Diabetic ☐ Tube Feed ☐ Supplement:

PHYSICAL STATUS

Falls Risk: _____ Weight: (kg)

Mobility: *Assistance* ☐ Independent ☐ Supervision +A ☐ Assist x 1 ☐ Assist x 2

Aide ☐ Nil ☐ FASF ☐ 4WW ☐ 2WW ☐ Stick/s ☐ Crutches ☐ W/Chair

Weight Bearing: ☐ N/A ☐ Partial ☐ Touch ☐ WBAT ☐ NWB (weeks): _____

Cognitive: ☐ Intact ☐ Confusion ☐ Delirium ☐ Dementia ☐ Wanderer

Continence: *Bladder* ☐ Continent ☐ Incontinent ☐ IDC

Bowel ☐ Continent ☐ Incontinent ☐ Colostomy

Personal Care: ☐ Independent ☐ Requires Assistance ☐ Fully Dependent

Vision: ☐ Normal ☐ Glasses ☐ Blind ○ Partial ○ Full

DOES THE PATIENT HAVE AN ADVANCED CARE DIRECTIVE ☐ No ☐ Yes

TRANSFERRING FACILITY DETAILS

Facility Name: _____ Ward: _____ Date Admitted: _____

Contact Person: _____ Phone: _____ Expected Transfer Date: _____

Discharge Destination: ☐ Home ☐ Aged Care Facility ☐ Transitional Care ☐ With: _____

REFERRER'S DETAILS

Referrer's Name: _____ Signature: _____

Provider No: _____ Date: _____

REFERRER'S DETAILS

Patient Signature: _____ Date: _____

True and Accurate Signed Referral Required

RECOMMENDATION FOR ADMISSION FORM