GREENWICH HOSPITAL
REHABILITATION REFERRAL FORM

TITLE	FAMILY NAME		MRN
GIVEN NAME		AMO	
ADDRESS	SUBURB	POST CODE	
DOB	SEX	ADMISSION DATE	

Phone NUM on 0417 450 941
When rehabilitation referral form is completed fax with copy of front page
Email to greenwichrehab@hammond.com.au or Fax to 9903 8332

Consent for faxing of patient information obtained ☐ Yes Date of Referral: _____/_____/_____

Referral Hospital/Ward: ______________________________

Estimated date ready for transfer to Rehabilitation Facility: _____/_____/_____

Main contact person (Name) ______________________________

______________________ ______________________ ______________________
Referring Clinician *Signature* *Designation*

Preadmission Support ☐ By Self ☐ Spouse / Carer ☐ Live in Non-Spouse ☐ Community Services

Usual Place of Residence ☐ Home ☐ Self Care Unit ☐ Hostel ☐ Nursing Home

Medical Details *Principal Diagnosis/Injury (Include date of last major intervention)*

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Pre-existing Conditions:

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____

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Diet ☐ Normal ☐ Minced ☐ Pureed ☐ Other: __________

Mobility Level ☐ Independent ☐ Assistance of 1 ☐ Assistance of 2 ☐ Other: __________

Using Walking Aid ☐ Yes ☐ No

If Yes ☐ FASF ☐ Rollator Frame ☐ PUF ☐ W/S ☐ Crutches

Transfer ☐ Transfer Independently ☐ 1 Person Transfer ☐ Other:

Weight Bearing Status ☐ Full ☐ Partial ☐ Touch ☐ Non-Weight Bearing

Behavioural (Comment on any confusion to time, place, person etc.)

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____

Infections: ☐ MRSA ☐ VRE Other: __________

Day Continence ☐ Yes ☐ No ☐ IDC/SPC/ Colostomy

Night Continence ☐ Yes ☐ No ☐ IDC/SPC/ Colostomy

Special Instructions for Rehab Provider *(eg : Tracheostomy, Wound Care, Dialysis, Infection Control / Swab Results etc)*

☐ None to Report

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BINDING MARGIN - PLEASE DO NOT WRITE

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