**Central Adelaide Local Health Network (CALHN)**

**Day Rehabilitation Service Referral Form (TQEH)**

**Phone:** (08) 8222 8169 **Fax:** (08) 8222 8021

**Email:** [Health.CALHNDayRehabilitationService@sa.gov.au](mailto:Health.CALHNDayRehabilitationService@sa.gov.au)*(please use REFERRAL as first word in subject line)*

**Client consented to referral? Yes**

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| --- | --- | --- | --- |
| Client Name |  | Sunrise UR |  |
| Street Address |  | Phone Number |  |
| Suburb & Post Code |  | Email |  |
| Interpreter Required? |  | Language |  |
| Sex | Male  Female  Other | Date of Birth / Age |  |
| Medicare Number |  | Expiry Date |  |
| NOK to be contacted to discuss referral in lieu of client? Yes  N/A  (provide details below) | | | |
| NOK Name |  | GP Name |  |
| Relationship |  | Practice / Address |  |
| Address |  | Phone Number |  |
| Phone Number |  | Fax / Email |  |
| Date of Discharge |  | Ward / Unit / Hospital |  |

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| DISCIPLINES REQUESTED *(minimum of two disciplines required for Multi-D rehabilitation program)* | | | |
| Clinical Psychology | Dietetics | Exercise Physiology | Neuropsychology |
| Occupational Therapy | Nursing | Orthotics & Prosthetics | Physiotherapy |
| Rehabilitation Medicine | Social Work | Speech Pathology |  |

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| CLIENT’S REHABILITATION GOALS *(please relate goals to the disciplines you have requested)* | |
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| 2 |  |
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| MEDICAL STATUS | |
| Presenting Condition  (e.g., date of onset, other acute medical issues) |  |
| Follow-up OPD Arranged | Clinic / Service: Date: |
| Past Medical History |  |
| Alerts  (e.g. allergies, bariatric, falls, MRO’s, safety, cognition, substance abuse, homelessness) | Current Weight: |
| Clinical issues  (e.g. pain, medications, continence, skin integrity, Community Wound Management plan) |  |
| Cognition / Perception / Mood / Motivation  (e.g., memory, behaviour, insight, mood)  *Please include scores from cognitive mood screening* |  |
| Communication / Sensory  (e.g., speech, swallowing, vision, hearing) |  |

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| --- | --- | --- | --- |
| Client Name |  | Sunrise UR |  |

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| SOCIAL / SUPPORT SERVICES | | | | |
| Usual Living Arrangements | Alone | With others | | Details: |
| Accommodation Type  *Please note any concerns, or if alternate arrangements on discharge please indicate plan and timeframe* |  | | | |
| Formal Support Services and/or Care providers |  | | | |
| My Aged Care | Yes  No | Application started: Yes  No  N/A | | |
| NDIS | Yes  No | Application started: Yes  No  N/A | | |
| Centrelink | Yes  No | Application started: Yes  No  N/A | | |
| Type of Centrelink payment (if applicable): | |  | | |
| Equipment  (including arranged for discharge) |  | | | |
| Home Modifications | Ongoing | Complete | Details: | |
| Other Relevant Information |  | | | |

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| FUNCTIONAL STATUS *(please include aids used)* | | | | | |
| Mobility (indoor / outdoor) |  | | | | |
| Transfers |  | | | | |
| Personal Care |  | | | | |
| Home Management |  | | | | |
| Occupation |  | | | Return to work goal: Yes  No | |
| Leisure / Hobbies |  | | | | |
| Driving / Transport  *Please consider plan for client to manage transport for DRS appointments* | Drives | Public Transport | Taxi/Access Cab | | NOK/Carer/Other |
| Licence suspended: Yes  No  Advised not to drive: Yes  No | | | Taxi Vouchers: Yes  No  Application started: Yes  No | |
| Other Relevant Information |  | | | | |

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| Referrer Name |  | Discipline |  |
| Service / Organisation |  | Contact Number |  |
| Email |  | Referral Date |  |

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| PLEASE ATTACH ALL RELEVANT INFORMATION INCLUDING DISCHARGE SUMMARIES, ASSESSMENTS, REPORTS AND A CURRENT MEDICATION LIST IF RELEVANT DOCUMENTS ARE NOT ACCESSIBLE ON SUNRISE |