Given Name(s): Address: Aboriginal Torres Strait Islander Both SUBSTITUTE DECISION MAKER/PERSON RESPONS Name: Patient Consent to referral: Yes No REFERRER DETAILS Name: Provider No. (if applicable): Have you or a member of your household returned from the second of the seco	Neither SIBLE/N Relation NOK av Signate Contact rom oversised that y sed you all ct with exp	Ils-Name: Interpreter/ IEXT OF KIN I Inship: ware of referra ure: ct Details-Phoi seas or interst rou should be re a close conf	ne/Pager # : tate travel in the las in home isolation for tact risk with a conf	Contact No: Designation: st 14 days? Yes No for coronavirus? Yes No firmed or suspected case of coronavirus?Yes No	
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Is anyone in your household or those you are in close contact DETAILS OF REFERRAL REFERRAL STREAM Inpatient Rehabilitation Home Rehabilitation*	ct with ex	Rehab DECT	symptoms of cough, s	-	
DETAILS OF REFERRAL REFERRAL STREAM Inpatient Rehabilitation Home Rehabilitation*		Rehab DECT		sore throat, fever, shortness of breath? Yes No	
REFERRAL STREAM Inpatient Rehabilitation Home Rehabilitation*					
Inpatient Rehabilitation Home Rehabilitation*					
Home Rehabilitation*		rax number.	•		
		Email: Health. SALHNDivRAPTriage@sa.gov.au			
*		All referrals need to be discussed and approved by the Home Rehabilitation Manager			
rplease complete additional information at bottom of t	please complete additional information at bottom of this form		404 030 Fax numb	ber: (08) 8404 2292 Email: homerehab@sa.gov.a	
leferring Hospital:		Ward/Location:			
Admission Diagnosis:		Date of Admission: Expected date of discharge:			
Past Medical History:			Weight: Allergies:	No. Describe:	
IND /Marifornias Voc.				No Describe:	
INR/Warfarin: Yes No Details:			Location: Wound Chart At	tached: Yes No	
Social History (home environment i.e. steps/access is:	sues fan	nily or informa		indired. Tes	
Usual Accommodation:		,	ш опррогод.		
Home Environment:					
Lives With:					
Family or formal supports prior to presentation:					
Social Issues that may impact discharge:					
Advanced Care Directive: Yes No Detail: Clearly indicated Resuscitation Status: Yes No	Data	.:ı.			
	Deta		.11.		
Infection Precautions/Concerns (include MRO status):		No Deta		MOCA.	
Cognitive Concerns: Yes Detail:	No	l v	/MSE:	MOCA:	
Behavioural Issues:					
Defiavioural issues.					
Summary of Current Medical Issues/Concerns (include	le if on O	2, diabetic):			
Current Medication (attach list if insufficient space):					

CURRENT LEVEL OF FUNCTION					
Name: MRN:	Date:				
ADLS:					
Current	Pre-morbid				
independent standby assist 1x assist 2x assist Dependent	independent assistance required				
Aid:	Specify:				
Comment:	Comment:				
TRANSFERS:					
Current	Pre-morbid				
independent standby assist 1x assist 2x assist Dependent	independent assistance required				
Aid:	Specify:				
Comment:	Comment:				
MOBILITY:					
Current	Pre-morbid				
independent standby assist 1x assist 2x assist Dependent	independent assistance required				
Aid:	Specify:				
Comment:	Comment:				
COMMUNICATION:					
Normal Dysphasia Dysarthria Dyspraxia Comment:					
CONTINENCE:					
Urinary: continent incontinent aids Comment:					
Facely continent incentinent aids Comments					
Faecal: continent incontinent aids Comment:					
MODIFIED DIET:					
Yes No If yes, specify (food & fluid):					
REHABILITATION GOALS- PLEASE INDICATE 3 OR 4 GOALS - Including	nursing goals as appropriate				
ADDITIONAL INFORMATION REQUIRED FOR HOME REHABILITAT	TION REFERRAL				
Consent to Visit: Yes No					
Discharge location: (own home, staying with family, RCF)					
Does client require Medication Management (including IVABx):					
Yes No Detail:					
Is assistance required with medications? Yes No If yes, 'Me	dication Authority' required (Send with d/c summary)				
Off-Site Risk Assessment Information provided to best of referrer's knowledge and reliant on details provided	by client / family*				
Known ETOH / Drugs / Aggression history: Yes No Detail:	of sicility same				
Smoker: Yes No Weapons: Y	'es No				
Pets: Yes No Detail:					
OVERALL RISK: High Medium Low					
*DISCHARGE SUMMARY FOR PATIENTS TRANSFERRING TO HOME	REHABILITATION TO ALSO INCLUDE (AS RELEVANT/ REQUIRED)				
UP TO DATE MEDICATION LIST					
1 WEEK HISTORY OF INR MONITORING/WARFARIN DOSING HISTORY					

PLEASE ENSURE THAT A COMPLETED DISCHARGE SUMMARY IS SENT TO THE RELEVANT SERVICE ON DAY OF TRANSFER

WOUND CHART

