**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*(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)* |
| 1 |  |
| 2 |  |
| 3 |  |
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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 |