



Referral for Assessment Rehabilitation / Aged Care

P.O. Box 50, Castlemaine Vic 3450

AFFIX PATIENT LABEL HERE

Surname: _____ Given Names: _____
Address: _____ Phone: _____
Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____
Present Location: _____ Phone: _____
Next of Kin or Person to Contact: _____ Phone: _____
Address: _____ Relationship: _____
Referring Doctor: _____ General Practitioner: _____
Pension No. _____ Veterans Affairs: _____ WorkCover: _____ TAC: _____
Private Health Fund Name and Member Number: _____

Service Required:

Table with 4 columns: Inpatient, Allied Health/Community Rehabilitation, Aged Care Assessment (ACAS), Residential Aged Care Management (RACM). Includes checkboxes for various services like Nutrition, Physiotherapy, Occupational Therapy, Podiatry, Speech Pathology, Continence, HARP, Residential Respite, Transition Care (TCP), Permanent Care, ACAS, Restorative Care, and Respite.

Mobility: _____
Lifting & Transfers: _____
Weight:kg
Barrier Nursing Required: _____
Mental State: _____
Pressure Areas: _____
Vision Impairment: _____
Hearing Impairment: _____

Does patient / NOK agree with referral? No Yes

CLIENT AWARE Castlemaine Health IS A NON SMOKING HOSPITAL

REASON FOR REFERRAL: (List disabilities, diagnoses & date of surgery)

MEDICAL HISTORY: (Current and Past) (Please attach copies of pathology / radiology results)

PRESENT MEDICATION: (or attach medication list)

Medical Practitioner Signed: _____ Print Name: _____ Date: _____

January 2010 F:\MedRec\Intranet Clinical Forms\Administrative\ReferralforAssessmentRehabilitationAgedCare.doc

REFERRAL FOR ASSESSMENT - Rehabilitation / Aged Care CR/date order

PATIENT NAME:

UR No:

NURSING:

Print Name:

Signature:

Designation:

Date:

PHYSIOTHERAPY:

Print Name:

Signature:

Designation:

Date:

OCCUPATIONAL THERAPY:

Print Name:

Signature:

Designation:

Date:

SOCIAL WORK / WELFARE:

Print Name:

Signature:

Designation:

Date:

DIETETICS / SPEECH PATHOLOGY:

Print Name:

Signature:

Designation:

Date:

PODIATRY / ORTHOTICS:

Print Name:

Signature:

Designation:

Date: