Eastern Health

AMPUTEE REHABILITATION CLINIC REFERRAL FORM

UR number:

Surname:

Given name:

Date of birth: DD/MM/YYYY Sex: M / F

(Affix hospital ID label if available - Internal use)

Do not send this form to the Community Access Unit.
Scan and email this form to: CRPIntakePJC@easternhealth.org.au

Referrer's name:		Designation:	
Location / organisation:			
Email:			
Referral date:	DD/MM/YYYY	Phone number:	

Reason for referral

HOPC:

Past medical history

Additional medical history: ☐ Attached

Social history

Pre-amputation consult	☐ Yes ☐ No Date of amputation: DD/MM/YYYY
Other clinics / specialists involved	
Does the client need to access Allied health e.g. PT/OT/SW for prosthetic rehab?	☐ No ☐ Yes Please completed an **Ambulatory Care and Community Services Referral Form** and fax to the EH Community Access Unit. Fax number: 9881 1102 or email: sacs.integratedcare@easternhealth.org.au

Name (Print): Signature:

Designation: Date: DD/MM/YYYY

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AMPUTEE REHABILITATION CLINIC REFERRAL FORM EH 011050

Eastern Health

AMPUTEE REHABILITATION CLINIC REFERRAL FORM

UR number:

Surname:

Given name:

Date of birth: DD/MM/YYYY Sex: M / F

(Affix hospital ID label if available - Internal use)

Client information

Surname:		Given name:	
Sex:	☐ Male ☐ Female ☐ Other	D.O.B.	DD/MM/YYYY Confirmed ☐ No ☐ Yes
Mobile number:		Phone number:	
Does the client have an NDIS-Approved plan?	☐ Yes NDIS coordinator:		
	☐ No		
	☐ To be commenced		
Interpreter required:	☐ No ☐ Yes	If yes, preferred language:	
Client's living arrangement:	☐ With family ☐ With Others ☐ Alone		
Usual accommodation:	☐ Independent ☐ Aged Care Residential ☐ SRS Other:		
Client's usual address:			
Client's temporary address: (or NA ☐)			
Name of carer(s) or NOK:			
Carer(s) / NOK Phone No:	☐ Phone ☐ Mobile		
To make an appointment contact:	☐ Client or ☐ Carer(s) / NOK		
GP details:	Name:		
	GP phone:		
	GP address:		
Client risks:	☐ Falls ☐ Pressure care ☐ Medication ☐ Allergies ☐ Living / carer situation ☐ Cognition ☐ Malnutrition ☐ Likely to present to hospital ☐ Nil identified ☐ Other:		
Strategies to manage risk:			
Staff risks:	☐ Violence ☐ Behaviour ☐ Home visit risk ☐ Drug and alcohol ☐ Hoarding ☐ Squalor ☐ Nil identified ☐ Other:		
Client is aware of referral and consents to receive requested service(s):			☐ No ☐ Yes
If no, provide details			
Client consents to sharing of relevant information as required			☐ No ☐ Yes
Client consents to receive information electronically (Including SMS)			☐ No ☐ Yes

EH 011050 AMPUTEE REHABILITATION CLINIC REFERRAL FORM