



**easternhealth**

GREAT HEALTH AND WELLBEING

**Sub Acute Referral for Admission Form**

Fax completed form to

Sub Acute Inpatient Access Unit: 8804 0490

UR Number: .....

Surname: .....

Given Name: .....

Date of Birth: / / Sex: M / F

(Affix Hospital I.D. Label if Available)

Date: ..... Assessed by: .....  
Campus: ..... Ward: ..... Treating Unit/Dr: .....

Medicare number: ...../..... Pension/HCC number: .....

Private Health Insurance?  Yes  No Fund:..... Membership No.....

GP Name:..... NOK name & contact number:.....

**Key Diagnosis:** .....

**Summary of current admission:** .....

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.....  
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.....  
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.....  
.....  
.....

**Past history:** .....

.....

**Premorbid situation:**

Mobility:.....

ADL's: .....

Cognition/ language: .....

Continence:.....

Living Arrangements: .....

**Current function:**

Mobility (incl weight bearing status): .....

ADL's:.....

Cognition/ language: .....

Nutrition: .....

Continence:.....

**Equipment Needs/ Special Requirements:**

- Single room  Wound management  Oxygen  PICC line
- Secure environment  Bariatric equipment (pt weight: ...kg)  Hydrotherapy  Nasogastric feeds
- Dialysis (No. of days ..... ) Other .....

**Plan/Goals:**

.....  
.....

**Stream**

Rehabilitation:

- Neurology / Stroke
- Ortho / Musculoskeletal
- Amputee
- General

- Geriatric Evaluation & Management (GEM)
- Potential Fast track

**Site:**  PJC  WH  AH  HDH  MH  BHH  
Clinical reason for site: .....

**Suitable for Afterhour's admission to a Subacute stand alone site:**  Yes  No

**If No, is this patient suitable for a Subacute admission on an acute site:**  Yes  No

**Date ready for transfer:** .....

**Expected LOS:** .....

**Expected discharge destination:** .....

**Signature:** .....

**Title:** .....



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SUB ACUTE REFERRAL FOR ADMISSION FORM

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