Eastern Health

GEM@Home Referral

E: GEMatHome@easternhealth.org.au
P: 0439 688 028 or 9955 1255

UR Number: _____

Surname: _____

Given Name: _____

Date of Birth: _____/_____/_____ Sex: M / F

Address: _____

Date: ……
Ward …….. Campus……

Assessed by: ……
Treating Unit/Dr: ……..

Key Diagnosis: ……

Admission date: Language: Interpreter required: Yes / No

Summary of current admission: ……
……
……
……
……
……
……

Past history: ……

Premorbid situation:
Mobility:……

ADLs: ……

Cognition/ Language:
……

Current function:
Mobility (incl weight bearing status): ……

ADLs:…… Cognition/ language:……
Nutrition: …… Continence: ……

Involved in care planning Yes ☐ No ☐ Agreeable to GEM@Home Yes ☐ No ☐

☐ Wound management ☐ Bariatric equipment (pt weight: …kg) ☐ Medication needs

Falls risk ☐ Amber ☐ Red IPAC Precautions ☐ No ☐ Yes- type Allergies ☐NKA ☐Yes-

PLAN/Goals for G@H admission:
……
……
.

Date ready for transfer: ……

Expected LOS: ……

Service Brokerage required:

PCA ☐
HH ☐
Shopping ☐
IHR ☐

Signature:

Phone:

EMAILED / /

FEH35200r

GEM AT HOME REFERRAL FORM

Updated March 2019 V2