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: .....
……..
……..
……..
……..
……..
……..
……

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:
……
……

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:

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: ……:

Signature: **Title:**

SUB ACUTE REFERRAL FOR ADMISSION FORM
EH 352000
FEH352000r