



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

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

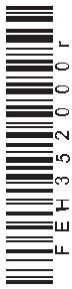
Date ready for transfer:

Expected LOS:

Expected discharge destination:

Signature:

Title:



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SUB ACUTE REFERRAL FOR ADMISSION FORM

EH 352000