



RHC101670



Ramsay Health Care

Rehabilitation Unit Pre-Admission & Referral Form

Surname: Given Name: Address: DOB: Sex: (Affix Patient Identification label here, if available)

Rehab Unit Name/Contact/Fax No/Email: Port Macquarie Private Hospital Inpt Ph: (02) 6582 9847 / Daypt Ph: (02) 6582 9789 / Fax: (02) 6583 6355

REFERRAL DETAILS

Referral to: (Optional) INPATIENT REFERRAL (assessed as requiring 24 hour nursing care) DAY PROGRAM REFERRAL (full day / half day)

Referring Dr: Signature: Ph: Provider No:

Referral Date: Requested admission date: Patient Ph: Person for notification: Address: Usual GP: Medicare No.: Exp: Patient Health Fund: Health fund No.: DVA No.: Workers Comp Third Party: Insurance Company: Claim number: Case Manager: Phone: Is the patient an existing NDIS participant? Pt Location: Ward: Bed: Ward Phone: Referrers Name: Position: Ward: Infectious Status (e.g. MRSA/VRE/ESBL/CRE positive): Results - Yes No (please attach results)

PATIENT DETAILS

Diagnosis / HPI / Complications Relevant Past Medical History Allergies Clinical Risks (e.g. Delirium) Social Situation Proposed D/C destination

CURRENT MOBILITY STATUS, LEVEL OF DEPENDENCE, ADLS

Mobility Transfers Weight bearing Cognition Falls Risk Continenence Showering Diet Fluids Medication

Previous functional status

REHABILITATION PLAN & GOALS

Patient willingness and ability to comply with program? Rehab Goals:

ASSESSMENT COMPLETED BY: Name: Signature: Date: ACCEPTED BY VMO: Name: Signature: Date:

Please send a copy of: 1) Recent progress and admission notes 2) Medication charts 3) Recent pathology results/scans and 4) ECG + any other information you feel is relevant to the referral.

BINDING MARGIN - DO NOT WRITE

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