Queensland Government

Metro North Hospital and Health Service

BRIGHTON REHABILITATION SERVICE REFERRAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Referral information

Referral date: ____ / ____ / ____

Reason for referral:

Referring Officer: Designation:

Referring facility:

Ward: Ward phone: Ward fax:

Contact details

Phone: 3631 7530 **Email:** Brighton_Rehabilitation@health.qld.gov.au

Consultant name: Date of admission: ____ / ____ / ____

Admitting diagnosis: Referring diagnosis:

Next of kin / contact ☐ Advised of referral

Name: Relationship:

Phone number(s):

Interpreter required: ☐ Yes ☐ No If yes, state language:

Current medical history and progress: Previous medical history:

☐ Wound care: ☐ IV medications:

☐ Stoma care: ☐ Oxygen therapy:

☐ Pressure care: ☐ Infection status:

Goal of rehabiltation / future plans:

Planned discharge destination:

☐ Pending investigations / Clinics:

☐ Patient has been informed of ongoing plan of care and consents to active participation

☐ Enduring Power of Attorney ☐ Statutory Health Attorney ☐ Acute Resuscitation Plan

☐ Guardianship ☐ Advance Health Care Directive

Financial status:

ACAS/ACAT assessment:

ACAS/ACAT expiry date: ____ / ____ / ____

Premorbid status – Psychosocial status:

Living circumstances: Social issues:

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MN042
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Family Name:

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Date of Birth: Sex: ☐ M ☐ F ☐ I

Community supports:

☐ Dom Nurses ☐ MOW ☐ Transition Care ☐ Family ☐ Community Health ☐ CHSP

☐ HCP level: ☐ Other:

Functional status

Home environment: Access:

Mobility: WB status:

Transfers: Mobility aids:

Hygiene/showering: Dressing:

Sensory impairment: ☐ Vision ☐ Hearing ☐ Speech ☐ Other:

Current functional status

Mobility:

WB status: Weight: Expected WB date: / /

Transfers: Mobility aids:

Hygiene/showering: Dressing:

Aids / equipment / assistance required for ADLs (e.g. O_2):

Toileting: Incontinence: Actions:

Sensory impairment: ☐ Vision ☐ Hearing ☐ Speech ☐ Other:

Perceptual impairment:

Cognitive function: Cognition details:

Behaviour / pain / mood issues: Communication:

☐ Sleep disturbance ☐ Swallowing difficulties ☐ Tracheostomy

Nutrition – diet/fluids:

Diet comments:

Current interventions

☐ Nil ☐ Social Worker ☐ Dietitian ☐ Occupational Therapy ☐ Palliative Care

☐ Physiotherapy ☐ Speech Pathology ☐ Podiatry ☐ Psychiatry/Psych Liaison ☐ Psychology

Followup required by referring hospital:

Other comments:

Referring Officer name *(print)*: Designation:

Signature: Date: / /

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