



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](mailto: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 rehabilitation / 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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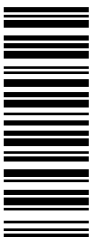
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All clinical form creation and amendments must be conducted through Health Information Services

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Locally Printed



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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<sub>2</sub>): \_\_\_\_\_

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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