Queensland Government

Sub-Acute Services Referral Form

TPCH Acute Ward to Metro North Subacute Services

Version 4.6

Service Referred to:

Referring Service:
Geriatric and Rehabilitation Liaison Service
The Prince Charles Hospital
Phone: 07 3139 5860
Fax: 07 3139 6696
Email: GLS-TPCH@health.qld.gov.au

REFERRAL COVER SHEET

Referrer's Name | Designation

Referring Facility

Ward | Unit | Ward Phone | Fax

Date | Number of sheets including this sheet

Date Medical team decided to refer (as per chart)

Reason for Referral

This patient has been reviewed by TPCH G&RLS Team to determine suitability.

If you have any queries, please contact via numbers or email listed above.

Developed by the Older Person Patient Flows Project RBWH/NHSD Working Party in consultation with stakeholders. Approved by the Steering Committee using funds allocated by the Clinical Practice Improvement Centre and Central Area Health Service. The services of the Nursing Applications Managment and Education Service at TPCH are acknowledged in developing this form.
RBWH G&RLS Updated: March 2011
RBWH G&RLS Review Date: March 2012

CONFIDENTIAL DOCUMENT

Referral Date | Referring Officer | Designation

Referring Facility

Ward | Ward Phone | Fax

Consultant Name | Date of admission

Admitting Diagnosis | Referring Diagnosis

Affix Patient Label

URN | Surname

Given Names

D.O.B | Phone

Address

NOK / Contact

Relationship

Phone | Advised of Referral

Interpreter

Current Medical History and Progress

Previous Medical History

Wound Care | IV Medications | Frequency

Stoma Care | Oxygen Therapy

Pressure Care | Infection Status

Goal of Rehabilitation/future plans:

Planned discharge destination: | Pending Investigations/Clinics:

Enduring Power of Attorney

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

Statutory Health Attorney

Advance Health Directive

Guardianship

Acute Resuscitation Plan

Financial Status

ACAS Assessment

ACAS Expiry Date

CONFIDENTIAL DOCUMENT

PREMORBID STATUS

Psychosocial Status

Living Circumstances

Social Issues

Community Supports
Tick all that apply

☐ Dom Nurses ☐ MOW ☐ Trans Care ☐ Family ☐ Community Health

☐ EACH ☐ CACP ☐ Other Specify

Functional Status

Home Environment

Access

Mobility

WB status

Mobility aids

Transfers

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 eg 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

Nutrition - Fluids

Current Interventions
Tick all that apply

☑ Nil ☐ Dietitian ☐ Occupational Therapy ☐ Physiotherapy ☐ Podiatry

☐ Psychiatry/Psych Liaison ☐ Psychology ☐ Social Worker ☐ Speech Pathology

Follow-Up required by referring hospital

Other comments

Referring Officer Name

Signature

Please go to Page 1 and Select Service Referred to