



Queensland
Government

The Prince Charles Hospital

Sub-Acute Services Referral

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: ☐ M ☐ F ☐ I

SUGGESTED SERVICE REFERRED TO: The Prince Charles Hospital

Referring Service:

Geriatric and Rehabilitation Liaison Service (GRLS)

The Prince Charles Hospital

Phone: **3139 5860**

Email: **GRLS-TPCH@health.qld.gov.au**

The contents of this referral are confidential to the addressee. It may also be privileged as it related to Health Service matters. Neither the confidentiality nor any privilege attaching to this referral is waived lost or destroyed by reason that it has been mistakenly transmitted to a person or entity other than the addressee. Unauthorised use, disclosure, copying or distribution of the contents of this referral is expressly prohibited. If you are not the addressee please notify us immediately by telephone or fax at the numbers provided above and return the fax to use by post at our expense.

REFERRER DETAILS

Referrer's name:

Designation:

Referring facility:

Unit:

Ward:

Ward phone:

Ward fax:

Referral date:

Referral outcome to be emailed to:

Consultant name:

Date of hospital admission:

Admitting diagnosis:

Next of kin / contact:

Relationship to patient:

Phone:

Interpreter required? ☐ No ☐ Yes ► language:

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

☐ Guardianship

Financial status:

☐ Statutory Health Attorney

☐ Acute Resuscitation Plan

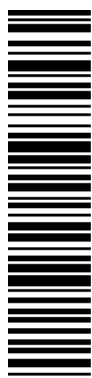
ACAS/ACAT assessment:

☐ Advance Health Directive

ACAS/ACAT expiry date:

DO NOT WRITE IN THIS BINDING MARGIN

v1.00 - 10/2021
Locally Printed



00004:01016

SUB-ACUTE SERVICES REFERRAL



Queensland
Government

The Prince Charles Hospital

Sub-Acute Services Referral

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: ☐ M ☐ F ☐ I

Current medical history and progress:

Previous medical history:

☐ Wound care:

☐ IV medications ► frequency:

☐ Stoma care:

☐ Oxygen therapy:

☐ Pressure care:

Infection status:

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

PREMORBID STATUS

Psychosocial Status

Living circumstances:

Social issues:

Community supports: ☐ Dom. Nurses ☐ MOW ☐ Trans. Care ☐ Family ☐ Community Health ☐ EACH ☐ CACP
☐ Other:

Functional Status

Home environment:

Access:

Mobility:

WB status:

Transfers:

Hygiene/showering:

Mobility aids:

Dressing:

DO NOT WRITE IN THIS BINDING MARGIN



Queensland
Government

The Prince Charles Hospital

Sub-Acute Services Referral

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: ☐ M ☐ F ☐ I

CURRENT FUNCTIONAL STATUS

Mobility:

WB status:

Weight:

Expected WB date:

Transfers:

Mobility aids:

Hygiene/showering:

Dressing:

Aids/equipment/assistance required for ADLs (e.g. O₂):

Toileting:

Incontinence:

Actions:

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

Perceptual impairment:

Cognitive function:

Cognition details:

Behaviour/pain/mood issues:

Communication:

☐ High visual bay ☐ Significant psychosocial issues

☐ Sleep disturbance ☐ Swallowing difficulties ☐ Tracheostomy

Nutrition - diet:

Diet comments:

Nutrition - fluids:

Follow-up required by referring hospital:

Other comments:

Referring Officer name:

Signature:

Designation:

Date: