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**

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 ☐ Statutory Health Attorney ☐ Acute Resuscitation Plan ☐ Advance Health Directive	Financial status: ACAS/ACAT assessment: ACAS/ACAT expiry date:

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SUB-ACUTE SERVICES REFERRAL

v1.00 - 10/2021
Locally Printed
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Queensland Government

The Prince Charles Hospital

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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:

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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. O_2):

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:**

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