



Queensland Government

Metro North Health

Healthy Aging Assessment Rehabilitation Team (HAART)

REFERRAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: M F I

Contact details- Bribie island HAART: BISH-HAARTIntake@health.qld.gov.au Ph: 3410 2876

Kallangur HAART: KSH-HAARTIntake@health.qld.gov.au Ph: 3285 0066

Medical History

Reason for referral

Does patient require Occupational Therapist (OT) home visit for hospital avoidance?: Yes No (if yes, please call if input is required within 24-48hrs) Specify why:

Patient consented to HAART referral: Yes No (if no, please contact Intake Officer to discuss further)

Medication listed on The Viewer/ My Health Record: Yes No Medication List attached Yes No

Is patient taking more than 9 medications currently? Yes No

Patient on high risk medications currently? (e.g. insulin, blood thinners, opioids, other pain medications) Yes No

Number of ED presentation/s in the past 12 months:

Is the patient medically stable and able to participate in a rehabilitation program currently? Yes No

General Practitioners (GP) name:

General Practice name:

General Practitioners address:

Alerts/Allergies (Check & update in ieMR as required- clinical,safety,medico-legal):

Next of kin (NOK) name: Relationship:

Best contact: Patient Carer NOK Relationship: Contact number:

Cultural:

Are you of Aboriginal and/or Torres Strait Islander Origin:

No Yes, Torres Strait Islander Yes, Aboriginal only Both, Aboriginal & Torres Strait Islander

Is an interpreter required: Yes No

Social history:

Lives: Alone With partner With family

Assessed by My Aged Care within last 12 months: Yes No

Home Care Package: Level 1 2 3 4

National Disability Insurance Scheme (NDIS): Yes No

Commonwealth Home Support Program: Yes No Nil known services

Home safety:

Previous OT home visit: Yes No - If no, are there home safety concerns or other concerns?

Cognition:

Recent changes to cognition: Yes No Is there known cognitive impairment: Yes No

Known to Geriatrician / Memory clinic: Yes -specify: No Unknown

Cognitive impairment impacting on Activities's of daily living (ADLS): Yes No

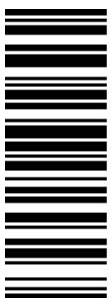
Any psychological or mood concerns: No Yes - specify

Current management strategies:

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V2.00 - 06/2025 Locally Printed



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Family Name:

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Address:

Date of Birth:

Sex: M F I

Psychological:

Any psychological or mood concerns: No Yes – specify:

Current management strategies:

Falls:

Number of falls in the past 12 months:

Vestibular issues: No Yes -specify:

Hearing/visual impairments: No Yes -specify:

Current mobility (*I = Independent, A = Assistance / With difficulty, S = Supervision*) Please check relevant box below:

	I	A	S	Aids used	Comments
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bed transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chair transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Toilet transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Current functional profile:

	Does patient require help in the following areas:	If yes, source of assistance?		Is additional assistance required:
		Formal service (write name if known)	Informal service e.g. family/friends	
Meal preparation	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic (cleaning, laundry)	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Hygiene – Showering, bathing, washing hair	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Communicating	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Toileting	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight management	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty eating / swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication management	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Shopping / Access to the Community	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Respite / Socialisation	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Transport	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No

Name:

Designation:

Signature:

Date:

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