MN444

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

Medical History (include reason for referral):

.....

.....

.....

.....

Does patient require Occupational Therapist (OT) home visit for hospital avoidance?: ☐ Yes ☐ No *(if yes, please call 3285 0066 if Rapid OT input is required within 24-48hrs)* Specify why: .....

.....

Patient consented to HAART referral: ☐ Yes ☐ No *(if no, please contact Intake Officer 3285 0071 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 ☐ 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: .....

HEALTHY AGING ASSESSMENT REHABILITATION TEAM REFERRAL

DO NOT WRITE IN THIS BINDING MARGIN

All clinical form creation and amendments must be conducted through Health Information Services

V1.00 - 04/2024
Locally Printed

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Given Names:

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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	☐	☐	☐		
Bed transfer	☐	☐	☐		
Chair transfer	☐	☐	☐		
Toilet transfers	☐	☐	☐		
Stairs	☐	☐	☐		

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	☐ Yes ☐ No			☐ Yes ☐ No
Domestic (cleaning, laundry)	☐ Yes ☐ No			☐ Yes ☐ No
Hygiene – Showering, bathing, washing hair	☐ Yes ☐ No			☐ Yes ☐ No
Communicating	☐ Yes ☐ No			☐ Yes ☐ No
Toileting	☐ Yes ☐ No			☐ Yes ☐ No
Weight management	☐ Yes ☐ No			☐ Yes ☐ No
Difficulty eating / swallowing	☐ Yes ☐ No			☐ Yes ☐ No
Medication management	☐ Yes ☐ No			☐ Yes ☐ No
Shopping / Access to the Community	☐ Yes ☐ No			☐ Yes ☐ No
Respite / Socialisation	☐ Yes ☐ No			☐ Yes ☐ No
Transport	☐ Yes ☐ No			☐ Yes ☐ No

Name:	**Designation:**
Signature:	**Date:**

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