



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:

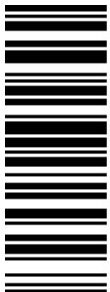
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All clinical form creation and amendments must be conducted through Health Information Services

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Locally Printed



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Government

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(HAART)**

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**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
<b>Mobility</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Bed transfer</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Chair transfer</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Toilet transfers</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Stairs</b>	<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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