The Sunshine Coast Private Hospital at Buderim

PATIENT LABEL

Family Name:

Given Name:

Address:

Phone: DOB:

Health Fund: Member No:

Please Tick: ☐ **Inpatient** ☐ **Day Program**

REFERRAL REQUEST FOR REHABILITATION SERVICES

Date of Referral: / / Doctor Referring:

Provider Number:

Diagnosis: Date of Surgery:

Relevant Medical Issues:

Social Situation: ☐ Lives alone ☐ Carer ☐ Care Facility ☐ Low care ☐ High Care

☐ Other:

Cognition: ☐ Alert ☐ Confusion ☐ Short Term Memory Loss ☐ Depression

CURRENT FUNCTIONAL STATUS

Social Situation: ☐ Normal ☐ Other:

Swallow: ☐ Normal ☐ Impaired

Diet: ☐ Normal ☐ Soft ☐ Minced ☐ Pureed ☐ Diabetic

Fluids: ☐ Normal ☐ Mildly Thick ☐ Moderately Thick ☐ Extremely Thick

	2 Person	1 Person	Supervise/ Setup	Independent	Equipment/Aid	Comment
Transfers						
Toileting						
Showering						
Dressing						
Mobility						
Eating						
Continence						

Infection Control: ☐ MRSA ☐ VRE ☐ ESBL ☐ Other:

General Comment/ Special Needs:

Health Professional Completing Referral: Date: / /

Signature: Contact No:

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