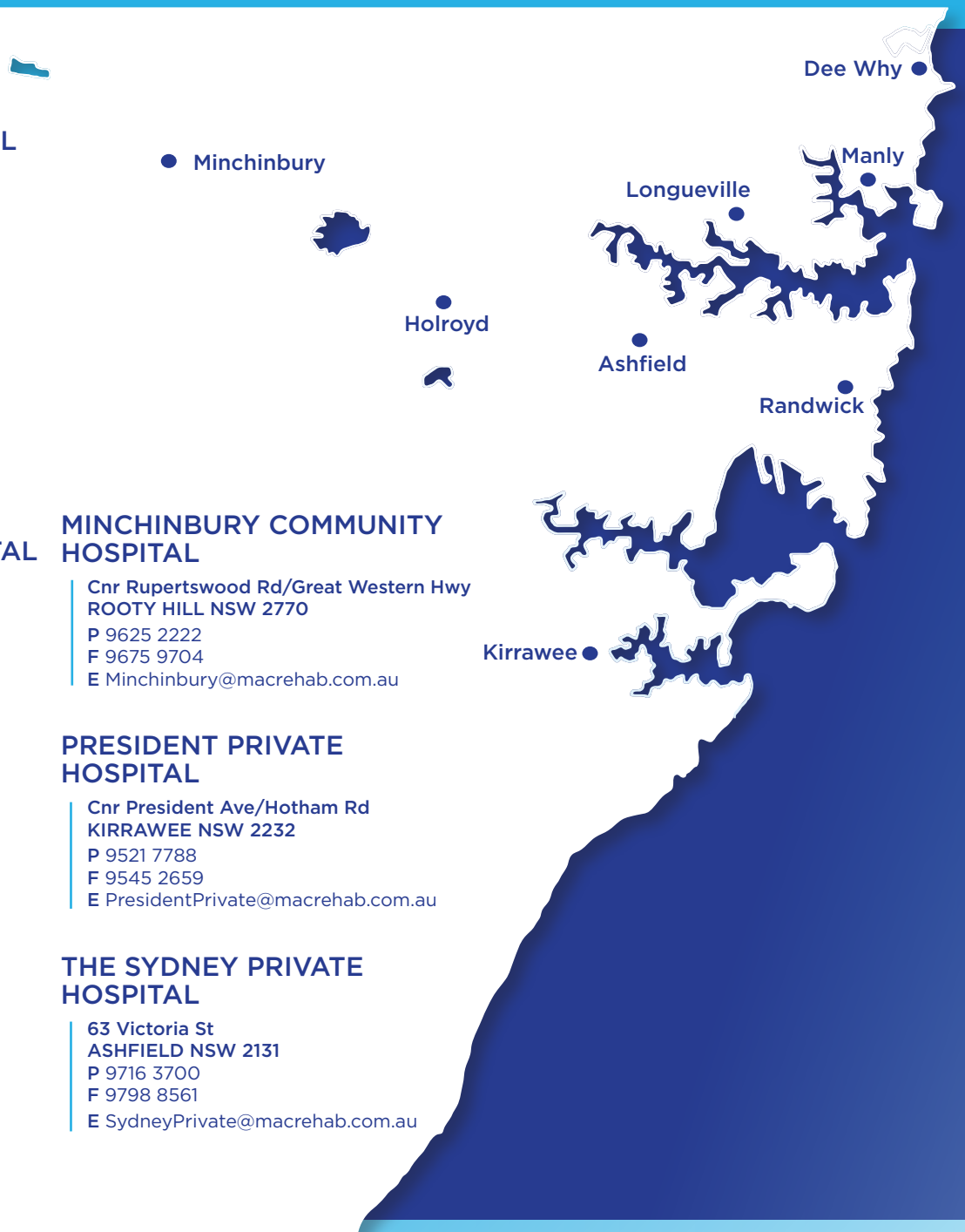
MacRehab

DAY

Rehabilitation Referral Form

1800 622 734 | MacRehab.com.au

SYDNEY METROPOLITAN
REHABILITATION LOCATIONS



DELMAR PRIVATE HOSPITAL

58 Quirk St
DEE WHY NSW 2099
P 9982 7655
F 9971 7299
E Delmar@macrehab.com.au

EASTERN SUBURBS PRIVATE HOSPITAL

8 Chapel St
RANDWICK NSW 2031
P 9398 0800
F 9398 8472
E EasternSuburbs@macrehab.com.au

HOLROYD PRIVATE HOSPITAL

123 Chetwynd Rd
GUILFORD NSW 2161
P 9681 2222
F 9632 8480
E Holroyd@macrehab.com.au

MINCHINBURY COMMUNITY HOSPITAL

Cnr Rupertswood Rd/Great Western Hwy
ROOTY HILL NSW 2770
P 9625 2222
F 9675 9704
E Minchinbury@macrehab.com.au

LONGUEVILLE PRIVATE HOSPITAL

47 Kenneth St
LONGUEVILLE NSW 2066
P 9427 0844
F 9418 7329
E Longueville@macrehab.com.au

PRESIDENT PRIVATE HOSPITAL

Cnr President Ave/Hotham Rd
KIRRAWEE NSW 2232
P 9521 7788
F 9545 2659
E PresidentPrivate@macrehab.com.au

MANLY WATERS PRIVATE HOSPITAL

17 Cove Ave
MANLY NSW 2095
P 9977 9977
F 9977 4319
E ManlyWaters@macrehab.com.au

THE SYDNEY PRIVATE HOSPITAL

63 Victoria St
ASHFIELD NSW 2131
P 9716 3700
F 9798 8561
E SydneyPrivate@macrehab.com.au

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HOSPITAL STICKER

INPATIENT/OUTPATIENT REHAB
Referral Form

Please PRINT clearly.
Fax/email to relevant facility.
To be completed by Specialist/ GP/Discharge Planner.

PROGRAM: ☐ INPATIENT REHAB ☐ OUTPATIENT Request start date:

PROGRAM TYPE:

☐ ORTHOPAEDIC ☐ RECONDITIONING ☐ FALLS PREVENTION/BALANCE ☐ CARDIAC ☐ LYMPHOEDEMA
☐ NEUROLOGICAL ☐ PAIN MANAGEMENT ☐ RESPIRATORY ☐ METABOLIC ☐ OTHER:

GOALS:

HOSPITAL LOCATIONS:

☐ Delmar Private Hospital ☐ Holroyd Private Hospital ☐ Longueville Private Hospital ☐ Eastern Suburbs Private Hospital
☐ Manly Waters Private Hospital ☐ President Private Hospital ☐ The Sydney Private Hospital ☐ Minchinbury Community Hospital

PATIENT DETAILS:

Title: Given names: Surname: Date of birth: Weight (kg): M ☐ F ☐

Address: Home Ph: Mobile:

Person responsible: Contact No: GP Name: Contact No:

Health Fund/DVA/Insurance Name: Membership/DVA No:

Medicare No: Ref No: Expiry:

CLINICAL DETAILS:

Reason for Referral:

Recent ACAT Assessment: ☐ Y ☐ N *Details:*

Relevant Medical History:

Current Medications:

Allergies:

Falls History:

Mobility: *Bed mobility* ☐ Independent ☐ Supervision ☐ Assistance
Sit to Stand ☐ Independent ☐ Supervision ☐ Assistance
Ambulation ☐ Independent ☐ Supervision ☐ Assistance ☐ Crutches ☐ Rollator
☐ W/Chair ☐ FASF ☐ PUF ☐ Stick/s

Weight Bearing: ☐ Full ☐ Partial ☐ Touch ☐ As Tolerated
☐ Non weight-bearing weeks:

Cognitive: ☐ Intact ☐ Confusion ☐ Delirium ☐ Dementia

Hydrotherapy: ☐ Y ☐ N *Commencement date:*

Infection: ☐ Y ☐ N *Details:*

Usual Living Arrangements: ☐ Own Home ☐ Rents ☐ Hostel ☐ Nursing Home

Lives: ☐ Alone ☐ W/Partner ☐ W/Relatives ☐ W/Carer

Swallowing Intact: ☐ Yes ☐ No ☐ NGT/PEG

Diet: ☐ Normal ☐ Diabetic ☐ Tube Feed ☐ Supplement:

INPATIENT DETAILS:

Hospital where patient is currently located: Date Admitted: Hospital Ph:

Contact Person: Referring Specialist: Estimated D/C date:

Falls Risk:

Risk of Pressure Injury: ☐ Y ☐ N Wound Management: ☐ Y ☐ N

MRSA Swabs Taken: ☐ Y ☐ N *Date:* *Result:*

Multi Resistant Organisms: ☐ Y ☐ N *Type:*

Continence: *Bladder* ☐ Continent ☐ Incontinent ☐ IDC
Bowel ☐ Continent ☐ Incontinent ☐ Colostomy

Personal Care: ☐ Independent ☐ Requires Assistance ☐ Fully Dependent

Discharge Destination: ☐ Home ☐ Aged Care Facility ☐ Transitional Care ☐ With:

REFERRER'S DETAILS:

Referrer's Name: Provider No.: Signature: Date: