

URN:

Surname:

Given name:

DOB:

Gender:

(Affix patient identification label here, if available)

Rehab at Home Referral

1. PATIENT DETAILS

Mobile number:	Cultural/language considerations?
Email:	
Address for discharge: (TICK IF THE ADDRESS FOR DISCHARGE IS ON THE BRADMA STICKER)	Is the patient of Aboriginal and/or Torres Strait Islander origin?
	<input type="checkbox"/> Aboriginal origin <input type="checkbox"/> Torres Strait Islander origin <input type="checkbox"/> Both Aboriginal and Torres Strait Islander origin <input type="checkbox"/> Neither Aboriginal nor Torres Strait Islander origin <input type="checkbox"/> Not stated/inadequately described
State: Postcode:	

NEXT OF KIN / EMERGENCY CONTACT DETAILS

First name:	Phone number:
Last name:	Relationship:

2. FUNDING DETAILS (PLEASE SELECT HOW THIS PROGRAM WILL BE FUNDED)

Hospital funded	Private Health Fund name:	Workcover	Other:
Membership Number/Claim Number:		If Workcover, case manager name:	
Case manager phone:		Case manager email:	

3. MEDICAL DETAILS

Hospital admission date:	Anticipated discharge date:	Hospital name:
Primary diagnosis and interventions / surgical procedures (if applicable):		
Past medical history:		
Any complications during current admission?	No	Yes Details:
Any cognitive impairment/delirium?	No	Yes Details:
Allergies:	No	Yes Details:
Active infection alerts:	MRSA	Hep B/C
	VRE	HIV
	Covid-19	Influenza
	Other (specify):	None
Specialist name:	Specialist phone:	Specialist email:
GP name and clinic:		
GP phone:	GP email:	

HOME VISIT STAFF SAFETY CHECKLIST

History of aggression or violence?	No	Yes	History of inappropriate behaviour?	No	Yes
History of illicit substance abuse?	No	Yes	Any other risks for home visiting?	No	Yes

Details:

4. CARE NEEDS ON DISCHARGE

Transfers	Independent	Supervision	1x Assist	2x Assist	Other (specify):
Mobility on discharge	Independent	Supervision	1x Assist	2x Assist	Distance:
Walking aid	Nil aid	Walking stick	Crutches	Frame	Wheelchair
Falls risk	No	Yes	Details if 'Yes'		
Weight-bearing status	WBAT	Partial	Protected	Touch WB	Non-WB
					No restrictions
Precautions / contraindications:					
Social history:					
Additional information:					

Supporting documentation (if applicable)

Specialist protocol with precautions/contraindications listed

Hospital discharge summary / Allied Health report

URN:

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Rehab at Home Referral

5. REHABILITATION AT HOME SERVICE REQUIREMENTS

Patient discharged from: Acute ward Inpatient rehabilitation

The patient would otherwise stay admitted in hospital for: day/s without home services

Service	Start date	Frequency (per week)	Program length (weeks)	SMART goals of clinical services requested
Physiotherapy				
Dietetics				
Occupational therapy				
Rehab nursing				
Personal care				
Home help				
Meals				

This patient **does not wish, or is not clinically suitable** to receive virtual / hybrid care for: PT OT

6. AUTHORISATION AND REFERRER DETAILS

By signing and sending this referral I declare that:

- The hospital treating specialist declares that the patient is medically stable.
- The patient is suitable to safely engage in home-based care.
- The patient has consented to receiving Ramsay Home Health services at home and has consented to their personal and health information being shared with Ramsay Home Health and the health fund nominated in this form, or the health fund's authorised agent.
- The patient has consented to Ramsay Home Health and the health fund nominated in this form contacting the patient, including by electronic means, to ascertain funding eligibility, confirm receipt and facilitate participation of the relevant services.
- The information provided in this form is complete, true and correct to the best of my knowledge.

Referrer name:

Referrer organisation:

Referrer role / title:

Referrer phone:

Referrer email:

Additional email:

Referrer signature:

Date: