Ramsay Home Health

URN:
Surname:
Given name:
DOB: Gender:
(Affix patient identification label here, if available)

Rehab at Home Referral

1. PATIENT DETAILS

Mobile number:
Email:
Address for discharge:
(☐ TICK IF THE ADDRESS FOR DISCHARGE IS ON THE BRADMA STICKER)
State: Postcode:

Cultural/language considerations?

Is the patient of Aboriginal and/or Torres Strait Islander origin?
☐ Aboriginal origin ☐ Torres Strait Islander origin
☐ Both Aboriginal and Torres Strait Islander origin
☐ Neither Aboriginal nor Torres Strait Islander origin
☐ Not stated/inadequately described

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 ☐ Other (specify):
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

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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:

RESET FORM

MR0053409 RC Rehab at Home 3pp A4 FORM 0525