pulsehealth

Mackay Rehabilitation Hospital

Full name: DOB:

Address:

Phone:

Medicare no.: *(Patient label)*

Present Location ☐	Hospital:	Ward:	☐ Home	☐ Other:
General Practitioner			Phone	
Specialist (if applicable)			Phone	
Health Fund: ☐ BUPA ☐ MBP ☐ HCF ☐ DVA ☐ Other:			Membership no:	

Primary Diagnosis for this referral:	Operations/ Date of operation:
Comorbidities:	Next of Kin – Relationship to patient: Phone:
	Allergies:

Referring Doctor

Date of referral

Signature

Provider number

CURRENT STATUS

Mobility	Independent	☐ No	☐ Yes		
	Assistance required	☐ No	☐ Yes	☐ 1 person	☐ 2 people
	Mobility aid required Type of mobility aid:	☐ No	☐ Yes		
Hygiene	Independent	☐ No	☐ Yes		
	Assistance required	☐ No	☐ Yes	☐ 1 person	☐ 2 people
Dressing	Independent	☐ No	☐ Yes		
	Assistance required Level of assistance required:	☐ No	☐ Yes		
Feeding	Independent	☐ No	☐ Yes	Diet	☐ Normal
	Assistance required Level of assistance required:	☐ No	☐ Yes		☐ Other:

Cognition:	**Continence** Bowels ☐ Cont ☐ Incont Urine ☐ Cont ☐ Incont ☐IDC
Communication:	**Wound/Pressure Area**
Transport ☐ Needs QAS ☐ QAS booked ☐ Able to sit in a car	
Special needs	
Additional information may be requested ○ Progress notes – first 3 days and last 3 days ○ Medication charts ○ Recent pathology results – last 2 – 3 days ○ Recent ECG ○ Allied Health reports	Fax completed referral to FAX 49428415 Direct line to referral manager Ph 0459050691