Government of South Australia
SA Health

CALHN Rehabilitation referral form

(Affix patient label here)

Unit Record No.: _____
Surname: _____
Given names: _____
Date of birth: _____ SEX: _____
Suburb:

I

Refer to: **Inpatient** ☐ **Rehab in the home** ☐ **2A Transition** ☐ **RAH Inreach** ☐

Referral date: Adm date: Patient phone:
Referring hospital: Ward:
Diagnosis: Procedure date:
Relevant past medical history:

Additional precautions/MRO's/Alerts: NO ☐ YES ☐ please specify:
Public patient ☐ Private patient ☐ Compensable ☐ Veteran ☐

S

Social profile:

Next of kin: Contact details:
Usual accommodation: House ☐ Unit ☐ RACF ☐ Other: ……
Lives with: Partner ☐ Alone ☐ Family ☐ Other: ……
Issues/concerns:
Does the patient identify as an Aboriginal or Torres Strait islander? No ☐ Yes ☐
Interpreter required: ☐ Language Spoken at Home:

B

Previous functional status:

Independent ☐ Needed assistance ☐ Aids used ☐ Specify: ……
Community services ☐ Specify: ……
Informal support ☐ Specify: ……
Comments/issues:

A

Current functional status: Weight:

	Independent	Needs assistance	Dependent		Specify:
Self care:	☐	☐	☐	……	……
Transfers:	☐	☐	☐	……	……
Mobility:	☐	☐	☐	……	……
Weight bearing status:	Full ☐	Partial ☐	Non weight bearing ☐	……	……
Urinary:	Continent ☐	Incontinent ☐	Aids ☐	……	……
Bowel:	Continent ☐	Incontinent ☐	Aids ☐	……	……
Cognition:	Intact ☐	Confused ☐	Challenging behaviour ☐	……	……

Memory difficulties: ☐ MMSE ☐ ……/30
Communication deficit: No ☐ Yes ☐ specify:……

Diet/swallow

Food: Normal ☐ Modified ☐ NGT ☐ PEG ☐
Fluid: Normal ☐ Modified ☐ Nil by mouth ☐

R

Rehabilitation goals:

Patient consent to referral: Signature: _____

Name and designation of referrer (printed):	Signature:	Date:
Contact details: Telephone:	Mobile:	Pager:

Patient Flow Coordinator - Moblie: 0421 098 528

Please email to Central Adelaide Rehabilitation Services - Patient Flow Coordinator

Email: Health.CALHNRehabService@sa.gov.au

November 2021

CALHN REHABILITATION REFERRAL FORM