

	The state of the s	
NALHN	PATIENT LABEL	
REHABILITATION	UNIT RECORD No.: SURNAME:	
KEHABIEHAHON	GIVEN NAMES:	
REFERRAL FORM	DATE OF BIRTH:	SEX:
LIB.C.C.	SUBURB:	et
	nt Rehab Rehab In 1	_
Referral Date:	Adm Date: Patient F	Phone:
Referring Hospital:	Ward:	na Data:
Diagnosis: Relevant Past Medical History:	Procedure Date:	
Relevant Fast Medical Filstory.		
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 Un		
Lives with: Partner Alone		
Issues/Concerns:		
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		
Bowel: Continent Incontiner	Aids	
Cognition: Intact Confused	Intact Confused Challenging Behaviour ifficulties: MMSE/30 cation Deficit: No Yes specify:	
Memory Difficulties: MMSE/30		
Communication Deficit: No		
Diet / Swallow		
Food: Normal Modified	NGT L PE	G_ L
Fluid: Normal Modified Nil by Mouth R REHABILITATION GOALS:		
Fluid: Normal Modified Nil by Mouth REHABILITATION GOALS:		
Patient Consent to Referral: Signature	e:	
Name & Designation of Referrer (printed):	Signature:	Date:
,		
Contact Dataile: Tolonbono:	Mobile:	Pager:
Contact Details: Telephone: Mobile:		Pager:
CPC - TRIAGE NURSE - MOBILE 0401 149 948 OR 0421 613 361		
Please email to Northern Adelaide Rehabilitation Service		
EMAIL: Health.NALHN Rehab Service@sa.gov.au		

October

2015