LAKEVIEW PRIVATE HOSPITAL

Day Program Referral Form

Patient Name:

Date of Birth:

MRN:

Stick patient label here

TO BE COMPLETED BY THE REFERRING HOSPITAL
Further details may be required on preadmission assessment. The rehabilitation physician will assess suitability of proposed admission into the day program.

PLEASE FAX TO: 02 8711 0255
EMAIL: dayprogram@lakeviewprivate.com.au

REFERRAL DATE:	REFERRING DOCTOR:	DISCHARGE DATE (if appropriate):
REFERRING HOSPITAL:	CONTACT NAME:	CONTACT NUMBER:

SECTION 1 PATIENT DETAILS

Surname		Given Names			
Title	Mr Mrs Ms Other		Age		Sex M / F / O
Address					
Suburb		State		Postcode	
Ph (H)	Ph (M)	Email			
Aboriginal Torres Strait Islander Both Neither Declined		Pension No.			
Medicare No.	Exp:	Veterans No.		White / Gold	
Home language		Health Fund			
Contact No.		Health Fund No.			
Next of Kin		GP (Family Doctor)			
Relationship		GP Address			

SECTION 2 FOR WORKERS COMPENSATION AND THIRD PARTY CLAIMS ONLY

Date of Accident	/ /	Claim No.	Insurance Company:
Phone:	Email:		Contact person:

SECTION 3 MEDICAL HISTORY / DIAGNOSIS

Current History / Diagnosis (including infections)		**Allergies** ☐ Yes ☐ No
		Allergy / Reaction:
Past medical history:		Surgeon's Precautions:
Epi-pen ☐ Yes ☐ No		

SECTION 4 FUNCTIONAL STATUS

Current Mobility Status	☐ Independent	☐ Supervised	☐ Assist	☐ Wheelchair
Current Transfers	☐ Independent	☐ Supervised	☐ Assist	☐ Lifter
Sit to Stand	☐ Independent	☐ Supervised	☐ Assist	☐ Lifter
Bed Mobility	☐ Independent	☐ Supervised	☐ Assist	☐ Lifter
Stairs	☐ Independent	☐ Supervised	☐ Assist	☐ Rails
Weight bearing Status	☐ Full Weight Bear	☐ Partial Weight Bear	☐ Touch Weight Bear	☐ Non-Weight Bear
Hydrotherapy clearance	☐ Yes ☐ No	**Means of transport**		

SECTION 5 THERAPIES REQUIRED

Physiotherapy / Exercise Physiology Group ☐ **Hydrotherapy** ☐

Occupational therapy ☐ **Balance Group** ☐

Other ☐ **Cardiac** ☐ **Cancer** ☐ **Breast Cancer** ☐

Available Days (circle): **Any** **Mon** **Tue** **Wed** **Thu** **Fri** **AM / PM**

SECTION 6 DAY PROGRAM CO-ORDINATOR

Date referral received	**Fund check status**
Patient appointment scheduled ☐ **Yes** ☐ **No**	**Name** **Sign**