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	Date of Birth	Age	Sex M / F / O
Address				
Suburb		State		Postcode
Ph (H)	Ph (M)	Email		
Aboriginal Torres Strait Islander Both Neither Declined to answer		Pension No.		
Medicare No.	Exp:	Veterans No.		White / Gold
Home language		Health Fund		
Next of Kin		Health Fund No.		
Contact No.		GP (Family Doctor)		
Relationship		GP Address		

SECTION 2: FOR WORKERS COMPENSATION AND THIRD PARTY CLAIMS ONLY

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

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 ☐ Tai Chi ☐

Neurological ☐ 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**

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