Rehabilitation at Home Referral to Ramsay Connect

Ramsay Connect

Phone 1800 799 732 | Email referral@ramsayhospital.com

1. REFERRER DETAILS

Hospital:	Phone:
Referrer name:	Email:
Referrer role:	☐ Preadmission referral ☐ Referral post hospital admission
Referrer Signature:	Date:
Treating doctor/surgeon:	Phone: / Email / Fax:

Hospital treating doctor/surgeon declares that the patient is medically stable, has suitable social support to safely engage in home-based care and is not being discharged against medical or allied health advice. The patient has consented to Ramsay Connect disclosing their personal information to the health fund nominated in this form, or its authorised agent (as applicable), to ascertain funding eligibility, confirm receipt of relevant services and facilitate participation. ☐No ☐Yes

Please also send through the following documents as relevant;

✓ Surgeon protocol ✓ Discharge summary ✓ Any relevant post-discharge orders

If referral is for Hospital Care at Home IV therapy or NPWT/VAC please also refer to the Hospital Care at Home checklist

2. PATIENT DETAILS

Name:		Next of kin:	
Address:		Next of kin phone:	
		Admission date:	Discharge date:
D.O.B:	Phone:	Health Fund:	
Email:	Mob:	Membership No:	
Usual GP:	Phone:	Email / Fax:	

Patient Consent

I declare the Rehabilitation at Home program has been explained to me, and wish to participate.

Signature of patient/guardian/family member:	Date:

3. PATIENT'S MEDICAL DETAILS (All areas of Patient's Medical Details must be completed)

Primary diagnosis: Interventions / Surgical procedures (if applicable):

Any complications during admission: ☐ No ☐ Yes, Details:

Medical History:

Social History:

Infections: ☐ None ☐ MRSA ☐ VRE ☐ CPE ☐ COVID-19 ☐ Other (please specify):

Any known allergies: ☐ No ☐ Yes, Details:

Is the patient receiving any other community care services? ☐ No ☐ Yes, Details:

Home visit staff safety checklist: History of aggression or violence? ☐ No ☐ Yes

History of inappropriate behaviour? ☐ No ☐ Yes History of substance abuse? ☐ No ☐ Yes

Are there any other risks for home visiting? (behavioural/social issues, domestic violence, infectious diseases) ☐ No ☐Yes

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Patient Name:	D.O.B:

4. PROGRAM REQUEST - REHABILITATION AT HOME (please select program and complete all required areas)

- ☐ RAH Hip and Knee Joint Replacement
- ☐ RAH Reconditioning
- ☐ BUPA EMU Program 1 (acute admission to RAH)
- ☐ BUPA EMU Program 2 (inpatient rehab to RAH)

ESTIMATE OF SERVICE REQUIREMENTS (PLEASE COMPLETE FOR REQUESTED SERVICES)

Service Required	Start Date	Frequency	Duration
☐ Rehab Nursing			
☐ Physiotherapy			
☐ Occupational Therapy			
☐ Dietetics			
☐ Personal Care			
☐ Home Help			
☐ Meals			

Patient would otherwise stay in hospital for ☐ days (best estimate) **MUST BE COMPLETED**

REHABILITATION GOALS (must be completed for all Rehab at Home patients)

Patient goals for Rehab at Home program:

FUNCTIONAL STATUS

Previous Functional Status (mobility and ADLs)

History of falls in the past 6 months? ☐ No ☐ Yes, Details:

Current Mobility Statu , Level of Dependence, ADLS

Mobility	☐ Indep ☐ s/v ☐ 1 Assist ☐ 2 Assist ☐ Immobile ☐ Walking Aid (Type): Distance: m
Transfers	☐ Indep ☐ s/v ☐ 1 Assist ☐ 2 Assist
Weight Bearing	☐ FWB ☐ WBAT ☐ Non ☐ Touch ☐ Partial Date of next review of WB status:
Falls Risk	☐ At Risk ☐ Minimal Risk No. Falls during current admission:
Continence	Bladder: ☐ Continent ☐ Incontinent ☐ IDC ☐ SPC Bowel: ☐ Continent ☐ Incontinent Toileting: ☐ Indep ☐ Supervision ☐ Assistance
Showering	☐ Indep ☐ Supervision ☐ Assistance
Wounds	☐ No ☐ Yes – Specify:

Anticipated D/C Mobility Status:

Any cognitive impairment / delirium? Please describe: