

Alfred Sandringham Caulfield

Unit:.....

REFERRAL TO SUB ACUTE SERVICES

UR:

Family Name

Given Names

Date of Birth

Gender: Male Female

Thank you for your referral to the Sub Acute Services at Caulfield Hospital

- You will be advised of the waitlist outcome within three business days
- For GEM referrals, it is expected that a geriatrician consultation has occurred prior to this referral

Enquiries / Referral to: Caulfield.bed.access@cgmc.org.au Ph (03) 9076 6422 Fax (03) 9076 6161



PATIENT PROFILE									
Phone number/s									
Patient location at time of referral					Admission Date				
Ward					Medicare Number				
Is interpreter required		<input type="checkbox"/> Yes <input type="checkbox"/> No		Language Spoken					
REFERRAL									
Referrers Name				Designation					
Referral Date				Phone / Pager					
Sub-acute referral to:	<input type="checkbox"/> GEM	<input type="checkbox"/> Spinal	<input type="checkbox"/> Amputee	<input type="checkbox"/> Burns	<input type="checkbox"/> General	<input type="checkbox"/> Orthopaedic	<input type="checkbox"/> Neuro		
Does patient have a GP?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Name					
		Address			Ph				
HISTORY OF PRESENTATION									
MEDICAL HISTORY <i>Allergies / Infection Prevention status</i>									
IS PATIENT MEDICALLY STABLE? <i>List pending investigations +/- management issues</i>									
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, list							
Secure environment required				<input type="checkbox"/> Yes <input type="checkbox"/> No					
SOCIAL HISTORY									
Living arrangements									
Home physical environment									
Person Responsible name							Ph		
Does patient have a POA / Guardian				<input type="checkbox"/> Yes <input type="checkbox"/> No					
Case Manager			<input type="checkbox"/> Yes <input type="checkbox"/> No	Name		Ph			

