BCH
Bass Coast Health

Inpatient Services Referral

Surname ..... U.R. No. .....

First Name ..... Gender .....

Date of Birth ..../..../.... Age .....

PATIENT LABEL

Doctor ..... Ward .....

Address .....

PLACE LABEL HERE

Please send via secure email to: **hscteam@basscoasthealth.org.au**

Reason for Referral *(i.e. Acute, Rehab, GEM, Stroke)*: _____

For all stroke rehabilitation / amputee rehabilitation, please contact the Geriatric Medicine Registrar via Bass Coast Health Switchboard on 5671 3333 or the Health Services Coordinator on 5671 3384

Referrer Details

Organisation: _____ Date of Referral: _____ /_____ /_____

Ward: _____ Nurse in Charge: _____

Ward Phone Number: _____ Other Contact Number: _____

Name, Designation of Referrer: _____ Date: _____ /_____ /_____

Patient's Medical Details at Referral

Anticipated date of transfer: _____ /_____ /_____ Date of Acute Onset: _____ /_____ /_____

Diagnosis / Medical Notes or Presenting illness:

_____

_____

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INPATIENT SERVICES REFERRAL

MR/280

BCH3280

INPATIENT SERVICES REFERRAL

MR/280

BCH Bass Coast Health

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Ongoing Acute Medical Issues / Goals for Sub-acute Inpatient Care:

_____

_____

_____

_____

_____

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_____

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_____

Past Medical / Mental Health History:

_____

_____

_____

_____

_____

Allergies/Adverse Drug Reactions: _____

Infections

Does the patient have any infectious risks?

☐ MRSA ☐ VRE ☐ CPE ☐ ESBL ☐ Covid

☐ Other Please Specify: _____

Next of Kin (NOK) Details

Name of NOK: _____

Relationship: _____

Telephone: _____

Contact (If different from NOK): _____

Relationship: _____

Telephone: _____

Guardian / Administrator

Power of Attorney: ☐ Yes ☐ No

Details: _____

Case Manager: _____

Care Package Type: _____

☐ Work Cover – If yes, No: _____

Private Health: ☐ Yes ☐ No

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Patient Goals and Expectations:

_____

_____

_____

Anticipated Discharge Destination: _____

Advanced Care Planning

Does the patient have an Advanced Care Directive? ☐ Yes ☐ No Details: _____

Goals of Care _____

Social / Family Supports

Lives: ☐ Alone ☐ Family ☐ Other: _____

☐ House ☐ Flat / Unit ☐ Aged Care Facility ☐ Other: _____

Please comment on patient's premorbid level of function

_____

_____

_____

_____

_____

_____

_____

Current Physical Function

Height: _____cm Weight: _____Kgs BMI: _____

Weight Bearing Status: _____

Cognition / Behaviour

Are there any Cognitive Concerns: ☐ Yes ☐ No

Are there any Behavioural Concerns: ☐ Yes ☐ No

Does the Person require Constant Observation / Special: ☐ Yes ☐ No

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Special Requirements (may include such issues as need for single room, pressure relieving devices, complex wound care management, stoma care, PICC line)

_____

_____

_____

_____

_____

Follow Up Tests / Appointments

Date	Time	Test / Appointment	Location

Please send via secure email to: **hscteam@basscoasthealth.org.au**

Enquiries to Health Services Coordinator on 5671 3384

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