# Rehab at Home Referral to Ramsay Connect

Ramsay Connect

## 1. PATIENT DETAILS

| | |
|---|---|
| First Name: | Last Name: |
| Date of Birth: | Gender: |
| Address for discharge: | |
| State: | Postcode: |
| Phone number: | Email: |
| Cultural/language considerations? | |

Is the patient of Aboriginal and/or Torres Strait Islander origin?

- ☐ Aboriginal origin
- ☐ Torres Strait Islander origin
- ☐ Both Aboriginal and Torres Strait Islander origin
- ☐ Neither Aboriginal nor Torres Strait Islander origin
- ☐ Not stated / inadequately described

**Next of Kin / Emergency Contact details**

| | |
|---|---|
| First name: | Last name: |
| Phone number: | Relationship: |

## 2. FUNDING DETAILS (Please select how this program will be funded)

☐ Private Health Fund ☐ Hospital funded

Health Fund Name:

Membership Number:

☐ Compensation body/Third party

Compensation Body Name:

Claim Number:

Case Manager Name:

Case Manager Phone

Case Manager Email:

## 3. MEDICAL DETAILS

| | |
|---|---|
| Hospital Admission Date: | Anticipated Discharge date: |
| Hospital Name: | |
| Primary diagnosis and interventions / surgical procedures (if applicable) | |
| Past medical history | |

Any complications during current admission? ☐ Yes ☐ No Details:

Any cognitive impairment/delirium? ☐ Yes ☐ No Details:

Allergies:

Infection control alerts ☐ MRSA ☐ Hep B/C ☐ VRE ☐ HIV ☐ Covid-19 ☐ Influenza ☐ Other *(specify):* ☐ None

| | |
|---|---|
| Specialist name: | |
| Specialist phone: | Specialist email: |
| GP name + clinic: | |
| GP phone: | GP email: |

**HOME VISIT STAFF SAFETY CHECKLIST**

History of aggression or violence? ☐ Yes ☐ No History of inappropriate behaviour? ☐ Yes ☐ No

History of illicit substance abuse? ☐ Yes ☐ No Any other risks for home visiting? ☐ Yes ☐ No

Details:

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| | |
|---|---|
| Patient name: | |
| DOB: | |
| Address: | |

*or affix bradma here*

## 4. CARE NEEDS

| | | | | | |
|---|---|---|---|---|---|
| Transfers | ☐ Independent | ☐ Supervision | ☐ 1x Assist | ☐ 2x Assist | ☐ Immobile |
| | ☐ Other *(specify):* | | | | |
| Mobility on discharge | ☐ Independent | ☐ Supervision | ☐ 1x Assist | ☐ 2x Assist | ☐ Immobile |
| | ☐ Other *(specify):* | | | | |
| Walking aid | ☐ Nil aid | ☐ Walking stick | ☐ Crutches | ☐ Frame | ☐ Wheelchair |
| | ☐ Other *(specify):* | | | | |
| Falls risk | ☐ Yes | ☐ No | Details if 'Yes' | | |
| Weight-bearing status | ☐ WBAT | ☐ Partial | ☐ Protected | ☐ Touch WB | ☐ Non-WB ☐ No Restrictions |
| Precautions / contraindications: | | | | | |
| Social History: | | | | | |
| Additional information: | | | | | |
| Supporting documentation (if applicable) | ☐ Hospital discharge summary / allied health report | | | | |
| | ☐ Specialist protocol with precautions/contraindications listed | | | | |

## 5. REHABILITATION AT HOME SERVICE REQUIREMENTS

Patient discharged from: ☐ Acute ward ☐ Inpatient rehabilitation

The patient would otherwise stay admitted in hospital for _____ day/s without home services

| Service | Start date | Frequency (per week) | Program length (weeks) | SMART goals of clinical services requested |
|---|---|---|---|---|
| ☐ Physiotherapy | | | | |
| ☐ Occupational therapy | | | | |
| ☐ Dietetics | | | | |
| ☐ Rehab Nursing | | | | |
| ☐ Personal Care | | | | |
| ☐ Home Help | | | | |
| ☐ Meals | | | | |

☐ This patient **<u>does not wish, or is not clinically suitable</u>** to receive virtual / hybrid care

## 6. AUTHORISATION AND REFERRER DETAILS

**By signing and sending this referral I declare that:**

- The hospital treating specialist declares that the patient is medically stable.
- The patient is suitable to safely engage in home-based care.
- The patient has consented to receiving Ramsay Connect services at home and has consented to their personal and health information being shared with Ramsay Connect and the health fund nominated in this form, or the health fund's authorised agent.
- The patient has consented to Ramsay Connect and the health fund nominated in this form
- The patient has consented to Ramsay Connect and the health fund nominated in this form contacting the patient, including by electronic means, to ascertain funding eligibility, confirm receipt and facilitate participation of the relevant services.
- The information provided in this form is complete, true and correct to the best of my knowledge.

| | |
|---|---|
| Referrer Name: | |
| Referrer Organisation | |
| Referrer Role Title: | Referrer Phone: |
| Referrer Email: | Additional email: |
| Referrer signature: | Date: |

RESET FORM