Hurstville Private Hospital

MEDICAL REFERRAL FORM		
HOSPITAL, WARD & PHONE NUMBER:		
REQUESTED ADMISSION DATE:	**PRIVATE:** ☐ **PUBLIC MEDICAL:** ☐	
REFERRING DOCTOR & PROVIDER NUMBER:		
PERSONAL INFORMATION		
Family Name:	Given Name:	
MRN:	DOB:	
Address:		
Contact Number/s:		
Social History: ○ Lives Alone ○ Lives with partner/spouse/family ○ Lives with carer		
Type of Accommodation: ○ House/Unit ○ Retirement Village ○ Nursing Home		
Next of Kin:	Emergency Contact No:	
Medicare No:	Ref:	
DVA No:	Card Type: ○ Gold ○ White ○ Other: _____	
Health Fund:	Fund Number:	
WC/CTP Co:	Claim Number:	
Claims Manager: _____ Contact Details: _____	Insurance Claim details (if applicable):	

MEDICAL HISTORY/REFERRING INFORMATION
Diagnosis:
Past Medical History:
Allergies / Alerts / Known Infections:
MRSA / VRE Screen Swab Attended: ⬭ Yes ⬭ No Result: Date:

Cognition Status: o Alert o Orientated o Co-operative o Confused o Dementia	**Mobility:** o Falls Risk o Sara Steady o Crutches o Frame o Stick/s o Independent
ADL'S: o Independent o Supervision o Min. Assist o Mod. Assist o Full Assist	**Continence:** o Continent o Incontinent Urine o SPC/IDC o Incontinent Faeces
Feeding: o Self o Assist o NGT o PEG o Diet (Diabetic etc):	**Skin integrity:** o Intact o Wound o Pressure Areas o Ulcers o Dressings Please provide details:
Patient Baseline:	**Patient Weight (kgs):**

Hurstville Private Hospital to complete
Admission Type:
Completed By:
Accepted by Consultant:
Via: Email / Phone / Fax Date & Time: _____ / _____/ _____ _____:_____