NQ0031

REHABILITATION SERVICES REFERRAL

Facility: .....

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

Please return completed forms to: Email: referralsrehab@mater.org.au Phone: 07 4727 4659 Fax: 07 4727 4669

Referral Details

Physician requested	☐ Dr Ola Otaiku ☐ Dr Anand Kumar ☐ Dr Raguharan Kathiresu ☐ Dr Ibrahim Ali ☐ Dr .....
Service requested	☐ Day patient ☐ Inpatient
Disciplines required *(minimum of 2 therapies)*	☐ Physiotherapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Dietitian ☐ Social Work ☐ Nurse ☐ Psychologist ☐ Orthotist/Prosthetist ☐ Exercise Physiologist ☐ Other *(specify)*: .....
Reason for referral	
Relevant history *(please attach report as necessary)*	
Infection control needs	☐ Yes ☐ No If *YES*, please list: .....
Recommended start date	..... / ..... / .....

Identified Goals for Rehabilitation

Main functional goals to be addressed through a multidisciplinary rehabilitation program.

1.

2.

3.

Referrer Details

Referrer stamp

Name:

Medical centre:

Contact details:

Signature: Date: ..... / ..... / .....

Please complete back page for all patients transferring to inpatient overnight rehab.

Binding margin - do not write. Do not reproduce by photocopying.
All clinical form creation and amendments must be conducted through Health Records.

REHABILITATION SERVICES REFERRAL

10/23
Ver. 4.00
NQ0031

mater health

REHABILITATION SERVICES REFERRAL

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

Transfer to Overnight (Acute hospital to complete)

All patients	**Yes**	**No**
1. Does the patient require **Rehabilitation**?	☐	☐
a. Does the patient have the cognitive capacity to participate in a rehabilitation program?	☐	☐
b. Does the patient verbalise a willingness to participate in the program?	☐	☐
c. Is the patient medically stable and at a level of recovery that enables their active participation in a rehabilitation program?	☐	☐
2. Is the patient suitable for a **Day Rehabilitation**?	☐	☐
a. Can the patient achieve optimal functional improvement by attending a Day Rehabilitation Program?	☐	☐
b. Are these services available to the patient?	☐	☐
3. Does the patient require an **Overnight Rehabilitation Program**?	☐	☐
a. Does the patient require treatment from a multidisciplinary team consisting of at least two therapies (e.g. physical therapy, occupational therapy, speech therapy) under the direction of a Physician in Rehabilitation Medicine?	☐	☐
b. Is an admission to an overnight rehabilitation facility required due to all of the following requirements? • 24 hour a day access to a registered nurse • Frequent rehabilitation team assessment and intervention • Rehabilitation therapy requiring such intensity, frequency and duration, as to make it impractical for the patient to receive therapy anywhere else other than in an overnight rehabilitation program	☐	☐
c. Is the admission to an overnight rehabilitation program expected to result in a significant functional improvement over a clearly defined period of time?	☐	☐
Reconditioning patients only	**Yes**	**No**
4. Has the patient been hospitalised for a **minimum of 7 consecutive days**? If *YES*, state number of days:	☐	☐
a. Has the patient had a recent ICU admission? If *YES*, date of discharge from ICU: ..... / ..... /	☐	☐

Joint replacement patients only		**Score**
5. a. What is your age group?	50–65 years	☐ *(2)*
	66–75 years	☐ *(1)*
	>75 years	☐ *(0)*
b. Gender?	Male	☐ *(2)*
	Female	☐ *(1)*
c. How far on average can you walk? (a block is 200 metres)	Two blocks or more (+/- rest)	☐ *(2)*
	1–2 blocks (+/- rest)	☐ *(1)*
	Housebound (most of the time)	☐ *(0)*
d. Which gait aid do you use? (more often than not)	None	☐ *(2)*
	Single-point stick	☐ *(1)*
	Crutches/Frame	☐ *(0)*
e. Do you use community supports? (Home help, meals on wheels, district nursing)	None or one per week	☐ *(1)*
	Two or more per week	☐ *(0)*
f. Will you live with someone who can care for you after your operation?	Yes	☐ *(3)*
	No	☐ *(0)*
	Total RAPT score *(out of 12)*	

If the patient's RAPT score is 6 or above, please provide information to explain the necessity for overnight Rehabilitation:

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