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| **S Southern Adelaide Local Health Network NOTE**- For any queries regarding referrals please contact   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **PATIENT DETAILS** | | | | | | **Surname:**  **Given Name(s):** | **DOB:** | | **Gender:**  M  F | **Phone:**  **Mobile:** | | **Address:** | **Medicare no:** | | | **MRN:** | | **GP Details** Name: Contact No: | | | | | **Postal address (if different to above):** | | **Interpreter/Language:**  **Y**  N  If yes details: ……………………….. | | | | **Patient Consent to referral Yes**   **No** | | **Aboriginal**  **Both**  **Torres Strait Islander**  **Neither** | | | | **SUBSTITUTE DECISION MAKER/PERSON RESPONSIBLE (IF APPLICABLE)** | | | | | | **Name: Relationship: Contact No:** | | | | | | **SOCIAL STATUS** | | | | | | **Usual accommodation:**  Home  Unit  Other Comment:  **Lives with:**  Spouse  Alone  Other Comment: | | | | | | **Support Services received in Community:** | | | | |   **Day Rehabilitation Services Referral Day Rehabilitation Service Manager** Contact Ph:**(08)** 8404 2269   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **REFERRAL DETAILS** | | | | | | **Hospital** (if applicable): | | **Ward/Location:** | | **Acute Admission Date:**  **Date of Surgery:**  (if applicable) | | **Diagnosis/Condition Requiring Rehabilitation:** | | | | | **Past Medical History:** | | | | **Allergies**: | | **Advanced Care Directive:** Yes No Details:  **Resuscitation Plan:** Yes No Details: | | | | | | **Infection Precautions/Concerns (include MRO status)** Yes No Details: | | | | | | **Current Behavioural/Cognitive Concerns**: | | | | | | **Current Medication (attach list if insufficient space):** | | | | | | **FUNCTIONAL STATUS (Comment on mobility, personal care, transfers, continence, communication and equipment required)** | | | | | |  | | | | | | **REHABILITATION GOALS-** **PLEASE INDICATE 3 OR 4 GOALS** | | | | | |  | | | | | | **REFERRER’S DETAILS** | | | | | | Name: Designation: Signature: | | | | | | Phone/Pager: | Provider# (if applicable): | | Date: | | |

**PLEASE FAX REFERRAL FORM TO 8404 2263 Email:** [**Health.SALHNDayRehabService@sa.gov.au**](mailto:Health.SALHNDayRehabService@sa.gov.au)