EDEN
Rehabilitation Centre

Rehabilitation Referral

Full name DOB

Address

Phone

(Patient label)

Present Location ☐ Hospital: Ward: ☐ Home ☐ Other:

General Practitioner Phone

Specialist (if applicable) Phone

Health Fund ☐ MBF ☐ MBP ☐ HCF ☐ DVA ☐ Other:

Primary Diagnosis for this referral:	Operations/ Date of operation:
Comorbidities:	Next of Kin – Relationship to patient: Phone:
	Allergies:

Referred to DR FIALLA / DR ECKERMAN for rehabilitation

Referring Doctor Date of referral

Signature Provider number

STATUS PRIOR TO DISCHARGE – Discharge planner to complete (Please refax if not relevant at time of referral)

Mobility	Independent	☐ No	☐ Yes		
	Assistance required	☐ No	☐ Yes	☐ 1 person	☐ 2 people
	Mobility aid required	☐ No	☐ Yes		
	Type of mobility aid:				
Hygiene	Independent	☐ No	☐ Yes		
	Assistance required	☐ No	☐ Yes	☐ 1 person	☐ 2 people
Dressing	Independent	☐ No	☐ Yes		
	Assistance required	☐ No	☐ Yes		
	Level of assistance required:				
Feeding	Independent	☐ No	☐ Yes		
	Assistance required	☐ No	☐ Yes		
	Level of assistance required:				

Diet	☐ Normal	**Continence**	Bowels	☐ Cont	☐ Incont
	☐ Other:		Urine	☐ Cont	☐ Incont ☐ IDC

Wound/Pressure Area

Transport ☐ Needs QAS ☐ QAS booked ☐ Able to sit in a car

Special needs

ESSENTIAL TO BE INCLUDED Copies of:
- Progress notes – first 3 days and last 3 days
- Medication charts
- Recent pathology results – last 2 – 3 days
- Recent ECG
- OT Report

Eden Rehabilitation Centre
50 Maple St, PO Box 94, Cooroy Qld 4563
P 07 5472 6472 **F** 07 **5447 7592**
W www.edenrehab.com.au

BINDING MARGIN – DO NOT WRITE

REHABILITATION REFERRAL