FNH360000

NORTHERN HEALTH

Northern Health

INPATIENT – REFERRAL FOR AGED CARE/ REHABILITATION/GEM CONSULTATION (ARC)

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: ____________________________

SURNAME: ____________________________

GIVEN NAME: ____________________________

DATE OF BIRTH: _______/_______/_______ SEX: ______________

I

❑ 3 points of ID checked

Unit making referral: ……………………………………. Ward: ……………………………………………………

Referral to: ……………………………………………. Date: ____/____/____ Time: _____:_____

S

Diagnosis:

………

Reason for Referral:

❑ Suitability for Continuing Care ie. ❑ GEM ❑ GEM@Home ❑ Rehabilitation ❑ GEM@RESI

❑ Advice regarding Residential Care

❑ Geriatrician clinical opinion. Specify clinical question: ……………………………………………

………

COVID VACCINATION STATUS: ❑ 0 ❑ 1 ❑ 2 ❑ Consented for vaccine if required ❑ Unknown

B

Past History:

……………………………………………………………
……………………………………………………………
……………………………………………………………
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Relevant supporting clinical information:

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……………………………………………………………
……………………………………………………………
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……………………………………………………………
……………………………………………………………
……………………………………………………………

Signature Referrer: ……………………………….. Role: ………………………….. Date: ____/____/____

A

Consultant Assessment and Recommendation:
(Detailed notes may be made in the Health Record. This section for consultant summary and recommendations only)

R

Outcome / Recommendation:

❑ Home with: ……………………………………………………………………………………………

❑ Refer Continuing Care – suitable for: ❑ GEM location…………………………………………………

❑ GEM@Home ❑ Rehabilitation ❑ Rehab@Home ❑ GEM@RESI

→ If GEM ❑ suitable for behavioural bed in KAW

❑ Refer to ACAS for ❑ Permanent Residential Care ❑Transition Care – Bed-based/Home-based

❑ Other: ………………………………………………………………………………………………………

Signature Consultant: ……………………………………. Date: ____/____/____ Time: ______:______

Name: ………………………………………………………. Designation: ………………………………………

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B

For patients accepted for waitlisting for Continuing Care – complete and fax /email this referral:

- Inpatient GEM or Rehab - ATSAS Fax: 8405 2805 Email: *#BECC – ACCESS BECC*
- GEM@Home - Email: *NHS - GEM at Home Referrals*
- GEM@Resi - Email: *GEM@RESI – referrals*

ALERTS: ……………………………………………………………………………………………………

Patient has the flu vaccination: ❑ Yes ❑ No ❑ NA
Infection Prevention Screening Tool completed: ❑ Yes ❑ No
Single room required: ❑ Yes ❑ No
Additional Precautions commenced: ❑ Yes ❑ No
If yes, please specify ……………………………………………………………………………………

NESB: ❑ Yes ❑ No Interpreter required: ❑ Yes ❑ No
Language spoken……………………………………………………………………………………………

CNS: ❑ Alert / Orientated ❑ Confused/Disorientated ❑ Wandering ❑ Impulsive
Limb Strength/Weakness…………………………………………………………………………………

CVS: ❑ Vitals Stable ❑ Altered MET criteria…………………………………………………………
Lines: ❑ IVC ❑ PICC ❑ Chest Port

RESP: ❑ RA ❑ Oxygen…………………………….❑ CPAP / BiPAP……………………………………

ENDO: ❑ Diabetic

GIT: Diet………….. ❑ NGT or PEG Continent: ❑ Yes ❑ No BLO……………Stoma: ❑ Yes ❑ No

REN: Continent ❑Yes ❑ No ❑ IDC

MUS/SKEL: PMLOF……………………………..
Current Mobility: ❑ Independent ❑ Assist ………. Current Aid……… Distance………………
❑ Unable ❑ Hoist - Type:…………………………………………………………
❑ Restrictions eg. NWB – Specify: ……………………………………………………
❑ Orthotics eg (brace, AFO) – Specify:…………………………………………………

DERM: Wounds……………………… Dressings………………………… ❑ VAC……………….❑ Drain tube
Pressure injury ❑ Yes ❑ No Air mattress ❑ Yes ❑ No

Specific Patient/ Bed Requirements:

❑ Isolation - Specify (including cytotoxic)…………………………………………………
❑ Air mattress
❑ Low Low Bed - ❑ Definitely required ❑ If possible
❑ Bariatric Bed / Equipment – Weight………………Height………………Girth……………………
❑ Specific equipment eg brace – Specify: ……………………………………………………………

Behavior Management

History of Code Grey: ❑ Yes ❑ No
Date of Last recorded Code Grey: ____/____/____ Reason ………………………………………………
Special required within last 48hrs: ❑ Yes ❑ No
Behaviour charts supplied: ❑ Yes ❑ No ❑ NA
Physical aggression within last 48hrs: ❑ Yes ❑ No ❑ NA
Wandering/intrusive: ❑ Yes ❑ No

Concerns or events during ward stay:……………………………………………………………………
……
……
……

Signature: ……………………………………… Date: ____/____/____ Time: _____:_____

Name: ……………………………………………… Designation: ……………………………………………