ROCKINGHAM GENERAL HOSPITAL

MURRAY DISTRICT HOSPITAL

REFERRAL FORM

WARD __________________________

DOCTOR __________________________

<table>
<thead>
<tr>
<th>Surname</th>
<th>UMRN</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Given Names</th>
<th>Birthdate</th>
<th>Sex</th>
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<table>
<thead>
<tr>
<th>Address</th>
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Next of Kin/Carer/Guardian

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Contact number</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Informed of planned transfer</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
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</table>

Referring Hospital/Agency

<table>
<thead>
<tr>
<th>Name of Senior Doctor</th>
</tr>
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<table>
<thead>
<tr>
<th>Name of referral contact person</th>
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<table>
<thead>
<tr>
<th>Referral contact person details</th>
<th>PHONE</th>
<th>FAX</th>
<th>Email</th>
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Date of referral

Reason for referral- please tick one option

- Care awaiting placement
- Post sub-acute care
- Non weight bearing period due to acute fracture
- End of life care that does not require specialist Palliative Care
- Other reason, please document-
ROCKINGHAM GENERAL HOSPITAL

MURRAY DISTRICT HOSPITAL
REFERRAL FORM

WARD __________________________

DOCTOR __________________________

SURNAME __________________________

UMRN __________________________

GIVEN NAMES __________________________

BIRTHDATE __________________________

SEX __________________________

ADDRESS __________________________

Active Medical Problems:

1 __________________________

2 __________________________

3 __________________________

4 __________________________

5 __________________________

Cognition:

Unimpaired Impaired Impaired with BPSD

Anxiety or depression Yes / No

Relevant Past Medical History:

1 __________________________

2 __________________________

3 __________________________

4 __________________________

5 __________________________

Diabetic (circle relevant option/s) diet control oral medication Insulin

Micro alert Yes / No Specify __________________________

Requires single room Yes / No

Oxygen therapy: Yes / No

Skin: Intact Pressure area (specify site and grade)____________________

Dressing __________________________

Nutrition (circle relevant option): NG tube PEG Feed __________________________

Oral intake Normal diet Modified diet (specify) __________________________
**MURRAY DISTRICT HOSPITAL REFERRAL FORM**

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<thead>
<tr>
<th>WARD</th>
<th>DOCTOR</th>
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</table>

**SURNAME** | **UMRN** | **GIVEN NAMES** | **BIRTHDATE** | **SEX** |
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**ADDRESS**

<table>
<thead>
<tr>
<th>Bowels</th>
<th>Continent</th>
<th>Incontinent</th>
<th>Stoma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bladder</td>
<td>Continent</td>
<td>Incontinent</td>
<td>Catheter in situ</td>
</tr>
</tbody>
</table>

**Reason for urinary catheter**

**Mobility**

- Independent with/without device. No hands on assistance required
- Hands on assistance of one person for any part of task/s
- Full assistance of one person plus device, eg hoist etc
- Requires 2 people to perform all or part of task/s

**Referrals for Care Awaiting Placement**

- Is the Aged Care Assessment completed, ACCR delegated? Yes No

**Approved for:**

Listed at three residential aged care facilities (if information available)

1. 
2. 
3. 

**Asset assessment completed and lodged** Yes No

**Is there a need for application to SAT?** Yes No

**Has an application to SAT been submitted?** Yes No

Date for SAT hearing
ROCKINGHAM GENERAL HOSPITAL
MURRAY DISTRICT HOSPITAL
REFERRAL FORM

WARD ____________________________
DOCTOR __________________________

SURNAME ____________________________ UMRN
GIVEN NAMES ____________________________ BIRTHDATE ____________________________ SEX ____________________________
ADDRESS ____________________________

Any further information that may assist with the referral and transfer of this patient?
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Printed Name of doctor completing this form
________________________________________________________________________

Signature of doctor completing this form ____________________________ Date ____________________________

Please ensure that the contact details provided at the top of this form are correct

Please fax completed form to Aged Care department
Fax 9599 4055
Phone 9599 4051
Email MDHAdmission@health.wa.gov.au

For MDH use only

Further information required Yes No
Issues requiring clarification

Patient referrals accepted Yes No
Date of acceptance ____________________________

Name of accepting clinician ____________________________

Placed on EBM Yes No