WOLPER
JEWISH HOSPITAL

8 Trelawney Street
Woollahra NSW 2025
Phone (02) 9328 6077
Fax (02) 9327 5973 *Hospital front office only*

IN-PATIENT REFERRAL ASSESSMENT

COMPUTER LABEL

Title	Family Name	M.R.N		
Given Names		A.M.O.		
Address	Street	Age	Sex	Ward
Suburb	Postcode	Admission Date		

REHABILITATION FAX: 8580 4821 **MEDICAL FAX: 9363 3085**

Date:	Patient Name:	D.O.B.:
Address:		
Referring hospital:	Ward:	Phone No.:
Referring Doctor:	Date of admission:	
Previous admission to Wolper: ☐ Yes ☐ No	Year:	**MRN:**
Interpreter required: ☐ Yes ☐ No	GP:	Health Fund No.:
Diagnosis:		
Co-morbidities:		
Date admission required:	Height: Weight:	Oxygen Therapy: ☐ Yes ☐ No

CATEGORY:	☐ Neurological ☐ Orthopaedic ☐ Reconditioning ☐ Medical ☐ Palliative
COGNITIVE STATUS:	☐ Alert ☐ Orientated ☐ Co-operative ☐ Confused ☐ Dementia ☐ History of aggressive behaviour ☐ Delirium ☐ Cognitive Screen ____/30
MOBILITY:	☐ W/Chair ☐ FASF ☐ Rollator ☐ PUF ☐ Stick/s ☐ Crutches ☐ Independent ☐ Amputee Details: _____
WEIGHT BEARING:	☐ Full ☐ Partial ☐ Touch ☐ Weight bearing as tolerated ☐ Non weight bearing Details: _____
BARIATRIC CARE:	☐ Yes ☐ No ☐ Specific equipment required
ADL's:	☐ Independent ☐ Supervision ☐ Moderate assist ☐ Minimal assist ☐ Full assist ☐ 1 assist ☐ 2 assist
CONTINENCE:	☐ Continent ☐ Incontinent urine ☐ Incontinent faeces ☐ SPC ☐ IDC Date bowels last open: _____/_____/_____ ☐ Ostomy ☐ Self-catheterising

Falls History:
HISTORY/OR RISK FACTORS FOR VTE/DVT:
Wound/Pressure Injury:
Allergies/ADR/Alerts:
Food allergies/Dietary requirements:
Advance Care Directive - Date: No CPR/Treatment limitation - Date:

INFECTION CONTROL SCREENING:	Known or suspected MRO ☐ Yes ☐ No Transmission-based precautions ☐ Yes ☐ No		
Details:			
Does the patient have any of the following (please circle) ☐ Yes ☐ No Fever / Vomiting / Diarrhoea / Suspected or confirmed infection / Recently received or current antimicrobials			
Details:			
Print name:	Signature:	Designation:	Date:
Comments:			

BINDING MARGIN — DO NOT WRITE

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