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	Gender	Ward
Suburb	Postcode	D.O.B.		

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

Date:	Patient name:	D.O.B.:
Address:		Health fund:
Referring hospital:	Ward:	Phone No.:
Referring doctor:	GP:	Date of admission:
Previous admission to Wolper: ☐ Yes ☐ No Year:		**Wolper MRN:**
Diagnosis:		
Co-morbidities:		
Date admission required:	Interpreter required: ☐ Yes ☐ No	**Wolper AMO:**

CATEGORY:	☐ Neurological	☐ Orthopaedic	☐ Reconditioning	☐ Medical	☐ Palliative
COGNITION & MENTAL HEALTH SCREENING	☐ Alert	☐ Orientated	☐ Co-operative	☐ Confused	☐ Dementia
	☐ Aggressive behaviour		☐ Delirium	☐ Cognitive screen ____/30	
	☐ Suicidal thoughts/self harm		☐ Emotional distress	☐ Depressed	☐ Anxiety
MOBILITY:	☐ W/Chair	☐ FASF	☐ 4WW	☐ 2WW	☐ Stick/s ☐ Crutches
	☐ Nil Aid	Details:			
WEIGHT BEARING:	☐ Full	☐ Partial	☐ Touch	☐ Weight bearing as tolerated	☐ Bed-bound
	☐ Non weight bearing	Details:			
BARIATRIC CARE:	☐ Yes ☐ No	☐ Specific equipment required (refer to OT)			
ADL's:	☐ Independent	☐ Set up only	☐ Supervision/prompting		
	☐ Minimal assist (1 assist)	☐ Moderate assist (1-2 assist)	☐ Full assist		
CONTINENCE:	☐ Continent	☐ Incontinent urine	☐ Incontinent faeces	☐ SPC	☐ IDC
	Date bowels last open: _____/_____/_____		☐ Ostomy	☐ Self-catheterising	

Falls (<12 month): ☐ Yes ☐ No	Height:	Weight:	O_2 Therapy: ☐ Yes ☐ No	
VTE/DVT Prophylaxis: ☐ Yes ☐ No Details:				Dietary Requirement:
Wound/Pressure Injury:				
Allergies/alerts:				
Advance Care Directive: ☐ Yes ☐ No Date:		No CPR/Treatment Limitation: ☐ Yes ☐ No Date:		
Other:				

INFECTION CONTROL SCREENING - MRO: ☐ Yes ☐ No Transmission-based precautions: ☐ Yes ☐ No
Details:

Does the patient have any of the following (please circle) ☐ Yes ☐ No
Fever / Vomiting / Diarrhoea / Infection (suspected or confirmed) / On antimicrobials

Print name:	Signature:	Designation:	Date:
Handover received from (print full name):			Date/time:

BINDING MARGIN — DO NOT WRITE

IN-PATIENT REFERRAL ASSESSMENT WJH 009