WOLPER
JEWISH HOSPITAL

8 Trelawney Street
Woolahra 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.		

FAX REFERRALS TO: 9327 5973

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

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

COVID-19 SCREENING:
Does the patient have any of the following (please circle) ☐ Yes ☐ No
Fever (≥37.5°C) or history of fever **OR** respiratory symptoms
OR fatigue, loss of smell, loss of taste, and/or muscle/joint pain?

In the last 14 days, or prior to onset of illness, has the patient had:
• Contact with a confirmed or probable COVID-19 case ☐ Yes ☐ No

DETAILS:

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

BINDING MARGIN — DO NOT WRITE

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