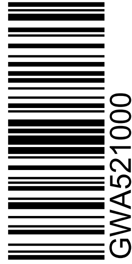

BINDING MARGIN – DO NOT WRITE

WESTERN NSW
LOCAL HEALTH DISTRICTS

Sub-Acute Care Team Referral Form
Orange Health Service

Facility

MRN	
Surname	
Other Names	
DOB/Sex	
Ward/VMO	

CONTACTS

Outreach Coordinator:	CNC Rehabilitation:	Facsimile:
0428 124 631	0400 864 211	02 6360 3906

Referral Date: ....

CLIENT DETAILS

DVA: ☐ Yes ☐ No Aboriginal/Torres Strait Islander: ☐ Yes ☐ No

Date Admitted to Facility: .... Medicare Nº: ....

NEXT OF KIN DETAILS

Name: .... Relationship to Client: ....

Address: ....

Home Tel: .... Work Tel: .... Mobile Tel: ....

REFERRAL DETAILS

Reason for Referral: (eg: assess patient suitability for inpatient rehab, advice for rehab goals in current environment)

....

Disciplines required:

- ☐ Physician (requires GP/VMO referral)
- ☐ Clinical Nurse Consultant
- ☐ Outreach Coordinator
- ☐ Physiotherapist
- ☐ Occupational Therapist
- ☐ Speech Pathologist
- ☐ Dietitian
- ☐ Social Worker

Diagnosis and Relevant Medical History:

....

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....

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INTAKE
****Office Use Only****

Referral Method: ....
Actions Taken: ....

....

....

Name: .... Signature: .... Date: ....

SUB-ACUTE CARE TEAM REFERRAL FORM

XXX XX