Goulburn Valley Health

Referral for Mary Coram Unit

☐ GEM ☐ REHABILITATION

Unit Record No: _____

Name: _____

Address: _____

Date of Birth: _____ Sex: Male / Female

Place Identification Label here

Present Location: _____ **Contact Number:** _____

Diagnosis: _____

Patient informed of referral: ☐ Yes ☐ No

Name: _____ **Signature:** _____

Designation: _____ **Date:** ____ / ____ / ____

Past Medical History: _____

Current Medical Issues *(Include admission date and op date)*: _____

(External referees please attach all current multidisciplinary and medical reports)

Current Medications: _____

Are there any conditions that require ongoing treatment/investigation? _____

Are there any conditions that require ongoing review/investigation? _____

Preferred time until admission to Mary Coram Unit: _____

Predicted duration of stay at Mary Coram Unit: _____

Living arrangements before Hospitalisation:

☐ Lives i/c their carer
☐ Lived alone
☐ Is carer for spouse/other
☐ Low Residential Care
☐ Other (specify): _____
☐ Lived with spouse/other
☐ High Residential Care
☐ Requiring Respite

Support Services before Hospitalisation:

☐ District Nursing
☐ Meals on Wheels
☐ Case Managed
☐ Home Help
☐ Respite in home

Name of case manager and organisation: _____

Does patient have: (if so please attach copy)

☐ An Administrator
☐ Enduring Power of Attorney: _____
☐ A Guardian

Expected Discharge Destination following Mary Coram Unit admission: _____

Referred by: _____

Name: _____ **Signature:** _____

Designation: _____ **Date:** ____ / ____ / ____

For Mary Coram Unit use only:

Arrived: _____ First Seen: _____ Review: _____

Priority: _____ Clinical Sub program. _____

Plan: _____

Reference No. N/A
Version No. 2
Date: 011007

MARY CORAM UNIT REFERRAL

MR2U

Part B

Patient name: _____ UR number: _____

ALLERGIES/DRUG SENSITIVITIES: ☐ Nil known

MOBILITY PREVIOUS ☐ Ambulant ☐ With Assistance ☐ Chair ☐ Bed

MOBILITY PRESENT ☐ Ambulant ☐ With Assistance ☐ Chair ☐ Bed

AIDS: PREVIOUS ☐ N/A ☐ Stick ☐ Frame ☐ Wheelchair ☐ Other: _____ ☐ Sent With Client

AIDS: PRESENT ☐ N/A ☐ Stick ☐ Frame ☐ Wheelchair ☐ Other: _____ ☐ Sent With Client

TRANSFER: PREVIOUS ☐ Independent ☐ Assist X 1 ☐ Assist X 2 ☐ Mechanical Lifter

TRANSFER: PRESENT ☐ Independent ☐ Assist X 1 ☐ Assist X 2 ☐ Mechanical Lifter

HYGIENE: PREVIOUS ☐ Self ☐ Partial Assist ☐ Full Assist ☐ Comments:

HYGIENE: PRESENT ☐ Self ☐ Partial Assist ☐ Full Assist ☐ Comments:

CONTINENCE: PREVIOUS *Bladder:* ☐ Continent ☐ Incontinent ☐ Catheter Inserted: _____

Bowels: ☐ Continent ☐ Incontinent ☐ Stoma (See Chart) Last Opened: _____

CONTINENCE: PRESENT *Bladder:* ☐ Continent ☐ Incontinent ☐ Catheter Inserted: _____

Bowels: ☐ Continent ☐ Incontinent ☐ Stoma (See Chart) Last Opened: _____

Aids Used/Comments: _____

COMMUNICATION: ☐ Speaks English ☐ Interpreter Required Language:

☐ Hearing Aid

Speech Impairment ☐ Yes ☐ No

VISUAL ACUITY: GLASSES ☐ Yes ☐ No

CONSCIOUSNESS/BEHAVIOUR: ☐ Alert/Orientated ☐ Aggressive ☐ Wanders ☐ Agitated ☐ Confused ☐ Drowsy

Comments: _____

SKIN INTEGRITY: ☐ Intact ☐ Reddened Areas (See Below)

☐ Wound - Describe: _____ ☐ Clips / Sutures Due Removal Date: ____ / ____ / ____

☐ Pressure Area

Comments: _____

DIET: ☐ Normal ☐ Diabetic ☐ Enteral ☐ Other (Specify Below)

Swallowing Difficulties ☐ Yes ☐ No ☐ Modified Diet Comment:

MRSA CLEARANCE: ☐ Yes ☐ No

ACAS ASSESSMENT: ☐ High Level ☐ Low Level Date Assessed: ____ / ____ / ____