



SM500460

South Metropolitan Health Service

SINGLE POINT OF REFERRAL ALLIED HEALTH AND COMMUNITY REHABILITATION

SITE: _____

Please use I.D. label or block print

Family Name	URN
Given Names	
Address	
D.O.B.	Gender

Site referring to (please tick):

- Fremantle Hospital and Health Service
 - For Community Rehabilitation: phone # 9431 3650; fax # 9431 3666
 - For Cardiovascular or Pulmonary Rehabilitation: phone # 9431 2060; fax # 9431 2131
- Rockingham General Hospital: phone # 9599 4877; fax # 9599 4700

Information for General Practitioners

Fax this form directly to the hospital site.

Patients requiring medical assessment should be referred via the Central Referral Service.

Referrals for Cardiovascular and Pulmonary Rehabilitation require a confirmed diagnosis.

PATIENT DETAILS – complete or attach

Previous name/s:

Phone:

Mobile:

Email:

Country of Birth:

Indigenous status: Aboriginal / Torres Strait Islander

Interpreter required: Yes No

Language and dialect:

NOK:

Relationship:

Phone:

Medicare Number:

Ref. no:

Exp:

DVA health card: Gold White Orange

GENERAL PRACTITIONER DETAILS

GP name:

Ph:

Fax:

Practice Name:

Email:

RELEVANT MEDICAL SPECIALIST DETAILS (e.g. Cardiologist, Respiratory Physician)

Name:

Hospital/Site

SERVICE REQUEST

- Community Rehabilitation**
(Interdisciplinary rehabilitation team)
- Falls Specialist
- Medical Review (internal referrers only)
- Cardiovascular Rehabilitation (CVR)
- Pulmonary Rehabilitation (PR)

Clinical Psychology

Dietetics

Nursing

Occupational Therapy

ACAT (Aged Care Assessment Team)

Permanent care Respite

Services at home

Physiotherapy

Podiatry

CAEP (Community Aids & Equipment Program)

Social Work

Continence clinic

Speech Pathology

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SMR64.1
07/16

SMR64.1 ALLIED HEALTH AND COMMUNITY REHABILITATION

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REASONS FOR REFERRAL/CLIENT CENTRED GOALS

MEDICAL HISTORY / STATUS (PMHx, allergies, precautions, red flags)

Investigation results/medications/medical summary attached Discharge summary attached

For CVR & PR referrer must provide: details of Oxygen Therapy; Lung Function (FEV₁ & FVC required for PR).

- if available: 6 minute walk test, echo report, stress test, angiogram, ventricular function;
- if applicable: ICD, PPM, PASP, PCI, stents.

Current exercise / activity tolerance:

SOCIAL SITUATION (eg living arrangements, carers, services in situ, red flags)

Documents attached Safety risk for staff visits – advise below

REFERRER DETAILS (if listed GP sign and date only)

Name:		Title/Position:
Phone:	Fax:	Email:
Address/Location:		
Feedback requested <input type="checkbox"/> Yes <input type="checkbox"/> No		
Signature:		Date:

TRIAGE SUMMARY

TRIAGE OFFICER USE ONLY - REFERRERS DO NOT COMPLETE

Service(s): _____	Priority:
Clinician(s)/Clinic(s): _____	<input type="checkbox"/> Urgent _____
_____	<input type="checkbox"/> Semi-urgent _____
	<input type="checkbox"/> Routine _____

Comments:

Triage Officer:	Signature:	Date:
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