

CONSULTATION REQUEST

Referrals can be faxed to:

Fax: [08] 9346 4966

or email:

DRACDayHospital.SCGH@health.wa.gov.au

Telephone: [08] 9346 2644

PATIENT DETAILS

Mr/Mrs/Ms/Miss

Unit No.

Surname

Sex: Female Male

Given Name

Date of Birth

Maiden Name

Contact
Telephone No.

Permanent
Address

Marital Status

.....Post Code.....

Present Address [if different from above]

.....Post Code.....

Medicare Number..... DVA Number.....

Is the patient aware of this Referral? Yes No

Primary Language..... Interpreter Needed Yes No

NEXT OF KIN FOR CONTACT [IF NECESSARY]

Name

Telephone
Home

Relationship

Telephone
Work

REFERRING DOCTOR

Name

Address

.....Post Code.....

PhoneFax

Provider Number

[stamp if applicable]

Reason for Referral

Medical Opinion
Specialist
preferred

Rehabilitation

ACAT Assessment
(ie Residential Care, Respite,
Home Care Services)

Home Falls Assessment

Home Equipment/Aids

Other

Day Hospital

Occupational Therapy/
Physiotherapy

Memory Clinic

Continence Clinic

Falls Clinic

COGNITIVE/BEHAVIOUR

- Normal
- Cognitive Impairment
- Depression
- Anxiety

MOBILITY

- Walks Alone
- Walks with Aid
- Walks with Assistance
- Chair/Bed Bound

CONTINENT?

- Urine Yes No Independent
- Faeces Yes No Independent

MEDICAL SUMMARY

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SOCIAL SITUATION

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CURRENT MEDICATION

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DOCTOR'S SIGNATURE: **DATE:**

This referral is valid for a 12-month period only