Health Western Cape

Better Care for Better Health, All Day, Every Day!

REFERRAL TO REHABILITATION OR LONG TERM FACILITY

Please keep in mind that each person in need of rehabilitation or sub acute care will be with the health care services for a long time – your time spent on a quality base line document will be a very worthwhile investment for other people along the line.
Failure to provide the information requested on all the pages will make it impossible to consider admission of the patient.
Please complete in detail and in legible handwriting.

THE COMPLETION OF THIS SECTION IS COMPULSORY

CLIENT'S PERSONAL INFORMATION

First name: ____________________ Residential address:

Surname: ____________________ ______________________________

____

Gender: ☐ Male ☐ Female ______________________________

ID No / Date of Birth: ______________________________

Contact no: ______________________________

Referring health worker: ____________________

Referring Hospital / Clinic: ____________________ Tel: ____________________

Hospital / CHC folder no: ______________________________ Date: ____________________

Dept: ____________________ E-mail address: ____

Ward: ____________________

Reason for referral – please tick the most appropriate block(s)

☐ Rehabilitation ☐ Tube feed ☐ other (describe)

☐ Nursing care: short term ☐ Terminal care ______________________________

☐ Nursing care: long term ☐ Respite ______________________________

____

Is this a self-referral? ☐ Yes ☐ No

Is this client known to a social worker? ☐ Yes ☐ No

If yes: Name: ____________________ Contact details: ______________________________

Is the client / next of kin aware of this application and the financial implications thereof?
☐ Yes ☐ No

Clients' Name:

Surname:

THE COMPLETION OF THIS SECTION IS COMPULSORY

Names and addresses of Responsible Relatives / friends / significant others:

Relationship	Name	Address	Telephone no.

FAMILY BACKGROUND

Home Language: ______________________

Client lives ☐ Alone ☐ With Name: ___________________ Relationship:____________________

Client's marital status Married ☐ Divorced ☐ Single ☐ Widowed ☐

Does Spouse work? ☐ Yes ☐ No

Housing Conditions ☐ Boarding ☐Self Owned ☐Rented ☐No fixed Abode

FINANCIAL CIRCUMSTANCES

Applicant is in receipt of ☐ A work pension ☐ Old age pension ☐ Disability grant

☐ Maintenance grant ☐ Attendant's allowance ☐ Other

Is the client currently employed? ☐ Yes ☐ No

Is the client expected to return to work? ☐ Yes ☐ No

Monthly income ☐ R0 – R4000 ☐ R4001 – R8000 ☐ More than R8000

Has application for pension / grant been lodged? ☐ Yes ☐ No ☐ N/A

Where: ______________________ When: ______________________

Is client on a medical aid? ☐ Yes ☐ No

Name of Medical aid: ______________________ Membership Ref. No. of Medical aid: ______________________

Does the applicant have a burial policy? ☐ Yes ☐ No

Name: ______________________ Value: ______________________

If relevant, WCA / RAF claim no.: ______________________ Date of injury: ____________________

Clients' Name:

Surname:

THE COMPLETION OF THIS SECTION IS COMPULSORY

GENERAL

Have the client and carer been informed of the prognosis? ☐ Yes ☐ No

Has an application been lodged at any old age home / institution? ☐ Yes ☐ No ☐ N/A

Name of institution: ____________________ Date lodged: ______________ Date approved: _____________

Community resources contacted (specify): ____
____
____

Future planning regarding discharge: ____
____
____
____
____

PRIMARY CARER CONTACT DETAILS:

The Primary Carer responsible for all matters related to client, including discharge planning:

Name: ______________________ **Relationship:** ______________________

Contact no.: __________________________________

E-mail address: ____

Information completed by:

Name: ______________________ Designation: ______________________

Contact no: _________________________________

E-mail address: ____ Date: ______________________

Clients' Name:

Surname:

THE COMPLETION OF THIS SECTION IS COMPULSORY

MEDICAL REPORT INFORMATION

A medical practitioner must complete this section. The referral will only be considered with the relevant information. If no medical practitioner is available, please indicate whether the client will:

☐ fax ☐ post ☐ deliver a medical discharge form.

Date of admission at referring hospital: ______________________

Date of discharge from referring hospital: ______________________

Diagnosis: ______________________

Date of onset: ______________________

Present symptoms:

Prognosis: ______________________

Clinical summary: (Please attach, if possible, copies of RELEVANT investigations and reports)

Please list all investigations done (as this avoids duplication). Please list all surgical interventions and dates.

Special needs regarding weight bearing and mobilization:

Clients' Name:

Surname:

THE COMPLETION OF THIS SECTION IS COMPULSORY

Is the client on medication? ☐ Yes ☐ No

If yes, please list below:
(On discharge, one month's supply of current medication must accompany the client. Please indicate if medications need to be tapered or discontinued, and if so, when.)

___

___

___

___

___

Follow up appointments or readmission date at referring hospital: ______________________

Medical information completed by:

Name: ___________________________ E-mail address: ____

Contact no: _________________________________ Date: ______________________

CARE INFORMATION

A nursing professional should ideally complete this section.

Does it appear as if the client is keen to help him / herself? ☐ Yes ☐ No

Have there been any previous attempts at rehabilitation? ☐ Yes ☐ No

Please provide further details:

	Totally dependant	**Physical / Verbal help**	**Supervision**	**Independent**
Eating / drinking	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Washing	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Walking	☐	☐	☐	☐

Is the client a wheelchair user? ☐ Yes ☐ No

If yes, propelling of chair	☐	☐	☐	☐
Transfer in / out of chair	☐	☐	☐	☐

Ownership of a wheelchair ☐ Bought ☐ Rented ☐ Loan ☐ Provincial Government

Are assistive devices used for walking? ☐ Yes ☐ No

If yes, what is used? ____

Clients' Name:

Surname:

Level of consciousness: ____

Nasogastric tube: ☐ Yes ☐ No **Tracheostomy:** ☐ Yes ☐ No

Bladder control: ☐ Continent ☐ Incontinent **Catheter:** ☐ Yes ☐ No

Catheter cared for by: ____

Bowel action: ☐ Continent ☐ Incontinent ☐ Constipation ☐ Normal ☐Diarrhoea

Body weight: ☐ Overweight ☐ Normal ☐ Underweight

Are there periods of confusion? ☐ Yes ☐ No

Does the client demonstrate aggressive behaviour? ☐ Yes ☐ No

Wounds / Pressure sores present ☐ Yes ☐ No

	Site	**Size**	**Depth**	**Current care**
If yes: Details of Wounds / Pressure sores				

Care information completed by:

Name: ______________________ ☐ Nurse ☐ Family member

E-mail address: ____

Contact no: _________________________________ Date: ______________________

Reviewed June 2006

Clients' Name:

Surname:

COMPLETION OF THIS SECTION IS COMPULSORY IF REFERRING CLIENT FOR REHABILITATION

FUNCTIONAL REPORT
An occupational therapist or a physiotherapist should ideally complete this section.

General status: ____

Respiration: ______________________ Sight: ______________________

Hearing: ______________________ Speech: ______________________

Bladder and Bowel control: ____

PHYSICAL STATUS:

		Left			Right		
Muscle power	Trunk	☐ /5			☐ /5		
	Upper limbs	☐ /5			☐ /5		
	Lower limbs	☐ /5			☐ /5		
		Decr	Normal	Incr	Decr	Normal	Incr
Basic tone / Spasticity	Trunk	☐	☐	☐	☐	☐	☐
	Upper limbs	☐	☐	☐	☐	☐	☐
	Lower limbs	☐	☐	☐	☐	☐	☐
Sensation	Trunk	☐	☐	☐	☐	☐	☐
	Upper limbs	☐	☐	☐	☐	☐	☐
	Lower limbs	☐	☐	☐	☐	☐	☐

		LEFT	RIGHT
Contractures	Upper limbs		
	Lower limbs		
Hand function	Grasp		
	Co-ordination		

Clients' Name:

Surname:

PHYSICAL ABILITY:

	Totally dependant	Physical / Verbal help	Supervision	Independent
Eating / drinking	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Washing	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Wheelchair user?	☐ Yes	☐ No		
Propelling of chair	☐	☐	☐	☐
Transfer in / out of chair	☐	☐	☐	☐

Wheelchair (only if yes above) Type: ______________________ Cushion: _____________________

Ambulation: Assistive devices: ______________________ Max.Distance:_____________________

Mental status: Orientated: ☐ Yes ☐ No Short-term memory intact? ☐ Yes ☐ No

Motivation: Poor ☐ Average ☐ Good ☐ Excellent ☐

TREATMENT GIVEN:

Physiotherapy:

Treatment given: ____

____

____

____

____

Progress of the client: ____

____

____

____

For how long was the treatment given and how often? ________________________________

____

____

____

Clients' Name:

Surname:

Occupational Therapy:

Treatment given: ____

____

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____

____

Progress of the client: ____

____

____

____

For how long was the treatment given and how often? ______________________________

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____

Speech Therapy:

Treatment given: ____

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Progress of the client: ____

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____

For how long was the treatment given and how often? ______________________________

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____

Physiotherapist information completed by:

Name: ______________________

E-mail address: ____

Contact no: _________________________________ Date: ______________________

Clients' Name:

Surname:

Occupational therapist information completed by:

Name: ______________________

E-mail address: ____

Contact no: _________________________________ Date: ______________________

Speech therapist information completed by:

Name: ______________________

E-mail address: ____

Contact no: _________________________________ Date: ______________________

PLEASE FAX THE COMPLETED FORM TO: 021 370 2400
FOR ATTENTION: THE WCRC BED MANAGEMENT TEAM

FOR FURTHER ENQUIRIES TELEPHONE: 021 370 2366/7