**Day Only Rehabilitation**

Tamara Private Hospital,

2-6 Dean Street

Tamworth NSW 2340

Phone Enquiries: 02 6764 5676

**Please fax or email all referrals**: **Fax: 02 6764 5680 Email:** [**DayRehab.TAM@ramsayhealth.com.au**](mailto:DayRehab.TAM@ramsayhealth.com.au)

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| Patient name: |
| Date of birth: |
| Address: |
| Home phone: |
| Mobile: |
| Medicare number: Ref: Expiry date: |
| Health insurance/DVA/Work Cover details:…………………………………………...  Relevant number:…………………….………………………………………………… |
| Next of Kin:  Contact details: |
| Program:  □ Neurological □ Reconditioning □ Orthopaedic □ Amputee □ Musculoskeletal |
| Therapies required:  □ Physiotherapy □ Occupational Therapy □ Exercise Physiology  □ Dietitian □ Speech Pathology □ Hydrotherapy |
| Presenting condition/relevant medical history:  **Expected date of discharge:** |
| Has the patient previously been treated for this condition by a specialist? □ Yes □ No  Please specify VMO………………………………………………………………….. |
| Is the patient aware of the referral and agreeable to attend the program? □ Yes □ No |
| Any issues that may impede the individuals participation in the program? i.e. acute pain/illness, significant cognitive/mental illness, communication difficulties? □Yes □No  If yes please specify………………………………………………………………. |
| Mobility aid: □Nil aid □Walking stick □Crutches □4WW □RF □ PUF □FASF □W/C |
| Current Mobility: □ Independent □ Supervision □ 1 x assist □ 2 x assist |
| Weight bearing: □ FWB □ WBAT □ PWB %....... □ TWB  Details: e.g timeframe……………………………………………… |
| Continence: □ Continent □ Incontinent □ Doubly incontinent |
| Toileting: □Independent □Supervision □Assistance |
| Showering: □Independent □ Set up only □Supervision □Assistance |
| Dressing: □Independent □Supervision □Assistance |
| Diet: □ Normal □Soft □Minced/Moist □Smooth Pureed |
| Fluids: □Thin/Normal □ Mild thick □Mod thick □Fully thick □ NBM……… |
| Cognition: MOCA score: ………………MMSE score………………….Other:……………………………. |
| Referrer Name (print):…………………………………………Signature:………………………….  Practice/Hospital:…………………………………………………………………………………….  Contact number:……………………………………………….Fax:………………………………...  Provider number:………………………………………………Date:………………………………. |