BARCODE

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Royal Rehab
The Rehabilitation & Disability Support Network

# Community Rehabilitation Service - External Referral

(CRSER.1116)

FAMILY NAME _____ MRN _____
GIVEN NAME _____ ☐MALE ☐FEMALE
DoB _____/_____/_____ M.O._____
ADDRESS _____
_____
LOCATION/WARD _____
COMPLETE ALL DETAILS OR AFFIX CLIENT LABEL HERE

| | | |
|---|---|---|
| **Date Referred:** | | **Expected Discharge Date:** |
| **Clients Name:** | | **Medicare No:** |
| **DOB:** | **COB:** | **Sex:** ☐ Male ☐ Female |
| **Address:** | | |
| **Phone Number:** | | |
| **Email:** | | |
| **Interpreter Required:** Yes/No | | **Language:** |
| **Contact Person:** | | **Relationship:** |
| **Phone Number:** | | **Email address:** |
| **General Practitioner:** | | **Phone:** |
| **Address:** | | |
| **Funding Source:** ☐ Medicare ☐ LTCS ☐ Compensable/Workcover ☐ DVA ☐NDIS ☐ Self-Funded | | |
| **Insurer Name:** | | **Claim/Participant No:** |
| **Total approved funding/hours allocated to this request (if applicable)** | | **Amount: $** **Hours:** |

**Service Referring to:**

☐ **Public Outpatients:** Fax: (02) 8088 3895 Phone: (02) 9808 9218

☐ **Home Based Rehab** (Multidisciplinary): Fax: (02) 8415 7122 Phone: (02) 9808 9687

☐ **Community Based Therapy:**
(including Lifestyle Support or NDIS) Phone: (02) 9808 9687

☐ **Return2Sport:** Email: return2sport@royalrehab.com.au Phone: (02) 9808 9353

| | |
|---|---|
| **Please Tick services requested:** | ☐ Social Work |
| ☐ Dietitian | ☐ Occupational Therapy |
| ☐ Neuropsychology (as required) | ☐ Physiotherapy |
| ☐ Nursing | ☐ Speech Therapy |
| ☐ Recreation | ☐ Aquatic Physiotherapy |

**Relevant Health Information** (Please attach medical/admission/discharge/medication summaries)

**Client aware of referral?** Yes/No **Urgent Referral?** Yes/No

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**Current Functional Status:**

Self Care: ☐ Independent ☐ Assistance Required Equipment used:

Transfers: ☐ Independent ☐ Assistance Required Equipment used:

Mobility: ☐ Independent ☐ Assistance Required Equipment used:

Comments:

**Communication issues:** Yes/No If Yes, provide details:

**Cognitive issues:** Yes/No If Yes, provide details

**Social issues:** Yes/No If Yes, provide details:

**Drug/Alcohol Issues?** YES/NO **Challenging Behaviours?** YES/NO **Falls Risk:** YES/NO

**Comments:**

**Reason for Referral:**

**Client Goals:**

**Any Other Services Involved / Organised for Client** (include contact details):

| | |
|---|---|
| **Referring Agency:** | **Name & Designation:** |
| **Phone number:** | **Contact email:** |

***CRS Office Use Only***

| | | |
|---|---|---|
| *Date Received:* | *Date Admitted:* | *Code:* |
| *CMS Clinic:* | | |
| *Estimated hours required to deliver service (if applicable):* | | |

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(CRSER.1116)

NO WRITING