East 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):
☐ Armadale Health Service: phone1300 884 502 / 93912512 fax 93912262 email akg.referrals@health.wa.gov.au
☐ Bentley Health Service: phone 9416 3213 fax 9416 3688

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

EMR64.1 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 (FEV$_1$ & 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 ☐ Yes ☐ No		
Signature:		Date:

TRIAGE SUMMARY

TRIAGE OFFICER USE ONLY – REFERRERS DO NOT COMPLETE

Service(s): ______________________

Clinician(s)/Clinic(s): ______________________

____

Priority:

☐ **Urgent** ______________________

☐ **Semi-urgent** ______________________

☐ **Routine** ______________________

Comments:

Triage Officer:	Signature:	Date:

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