



## 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the client a wheelchair user?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, propelling of chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer in / out of chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ownership of a wheelchair	<input type="checkbox"/> Bought	<input type="checkbox"/> Rented	<input type="checkbox"/> Loan	<input type="checkbox"/> Provincial Government
Are assistive devices used for walking?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Care information completed by:

Name: \_\_\_\_\_  Nurse  Family member

E-mail address: \_\_\_\_\_

Contact no: \_\_\_\_\_ Date: \_\_\_\_\_

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	<input type="checkbox"/> /5			<input type="checkbox"/> /5		
	Upper limbs	<input type="checkbox"/> /5			<input type="checkbox"/> /5		
	Lower limbs	<input type="checkbox"/> /5			<input type="checkbox"/> /5		
Basic tone / Spasticity	Trunk	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>
	Upper limbs	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>
	Lower limbs	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>
Sensation	Trunk	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>
	Upper limbs	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>
	Lower limbs	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>	Decr <input type="checkbox"/>	Normal <input type="checkbox"/>	Incr <input type="checkbox"/>
		LEFT			RIGHT		
Contractures	Upper limbs	<input type="text"/>			<input type="text"/>		
	Lower limbs	<input type="text"/>			<input type="text"/>		
Hand function	Grasp	<input type="text"/>			<input type="text"/>		
	Co-ordination	<input type="text"/>			<input type="text"/>		

**Clients' Name:**

**Surname:**

**PHYSICAL ABILITY:**

	Totally dependant	Physical / Verbal help	Supervision	Independent
Eating / drinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair user?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Propelling of chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer in / out of chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Progress of the client: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

For how long was the treatment given and how often? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Speech Therapy:**

Treatment given: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Progress of the client: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

For how long was the treatment given and how often? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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**