West Moreton

Queensland Government

Community Based Rehabilitation Team (CBRT) Referral

Facility:……

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date of Referral:_____ Hospital/Service D/C Date:_____

Completed with: ☐ Patient ☐ Other _____ Location: _____

Best Contact Number on Discharge: _____ Referral Source (PI5)_____

Reason for Referral to CBRT:

☐ Occupational Therapy _____

☐ Social Work_____

☐ Speech Pathology _____

☐ Physiotherapy _____

☐ Psychology _____

☐ Nursing _____

For Internal Referrals Only:

☐ Rehabilitation Physician – Dr_____ in _____weeks Reg OK? ☐ Yes ☐ No

Medical review not required ☐

Details of presenting condition (incl. date onset): _____

Diagnosis: _____

Relevant previous medical and surgical history: _____

Current Medications: _____

Allergies: _____

Smoker: ☐ Yes ☐ No ☐Ex _____ **Alcohol**: ☐ Yes ☐ No _____

Skin Intact: ☐ Yes ☐ No If No – current management care plan: _____

Living Situation: _____

ACAT assessment ☐ Yes ☐ No **NDIS Plan** ☐ Yes ☐ No

Type of care currently approved

☐ Level 1/2 package ☐ Level 3/4 package Respite Care ☐ Permanent Residential Care ☐

Formal Community Supports _____

Transport to CBRT _____

Discharge Programs **TCP** ☐ Yes ☐ No **HITH** ☐ Yes ☐ No **Nurse Nav** ☐ Yes ☐ No

Name: _____ **Designation:** _____ **Signed:** _____ **Date:** _____

Contact Details: (Service Name and Phone No.)_____

COMMUNITY BASED REHABILITATION TEAM (CBRT) REFERRAL

V14.00 01/2020
00015:14062

Queensland Government

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Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Other relevant Information

Name: **Designation:**

Signature: **Date:**

PLEASE FAX COMPLETED FORM TO WMH CRU:
HOSPITAL DISCHARGES (07) 3413 7277
ALL OTHER REFERRALS (07) 3810 1438