West Moreton

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.)______________________

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V14.00 01/2020

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

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