

# North Metropolitan Area Health Service

Department of Rehabilitation & Aged Care, Osborne Park Hospital

Fax: 9346 8232

Ph: 93468111 (referrals clerk)

## Consultation Request

<b>Name:</b>	<b>Date of birth:</b>
<b>Present address:</b>	<b>Sex:</b>
<b>Permanent address (if different):</b>	<b>Marital status:</b> Single/Married/Widowed/Separated
<b>Medicare number:</b>	<b>DVA eligibility:</b> Gold/White card Number:
<b>Hospital insurance:</b> Yes/No <b>If yes, name of fund:</b>	<b>Next of kin name:</b> <b>Relationship:</b> <b>Contact details:</b>
<b>Referring doctor details:</b>	<b>Indefinite referral:</b> yes/no
<b>Specialist required:</b> <input type="checkbox"/> Osborne Park Hospital physician <input type="checkbox"/> Joondalup Hospital physician <input type="checkbox"/> Aged Care Psychiatrist (Osborne Park Psychiatric Lodge)  Please comment if specific physician requested:	<b>Reason(s) for referral:</b> <input type="checkbox"/> Medical opinion <input type="checkbox"/> Rehabilitation/ day hospital therapy <input type="checkbox"/> Parkinson's clinic <input type="checkbox"/> Memory clinic <input type="checkbox"/> Falls clinic <input type="checkbox"/> ACAT <input type="checkbox"/> Permanent care <input type="checkbox"/> Respite <input type="checkbox"/> Community care (support services in the community) <input type="checkbox"/> Home aids <input type="checkbox"/> Continence assessment
<b>Mobility:</b> <input type="checkbox"/> Walks alone <input type="checkbox"/> Walks with aid <input type="checkbox"/> Walks with help <input type="checkbox"/> Confined to bed/chair only	<b>Mental state:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Altered <input type="checkbox"/> Wanders <input type="checkbox"/> Aggressive
<b>Continence:</b> <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent	<b>Presence of depression:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

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**Pathologies, disabilities and handicaps:**

**Past medical history:**

**Medication:**

**Allergies:**

**Please enclose relevant summaries, letters and pathology results**

<b>Is this person aware that the request has been made? Yes/No</b>
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Date:

Signature:

Patient surname (this assists if the 2<sup>nd</sup> page is misplaced): \_\_\_\_\_