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| <p><b>Osborne Park Hospital</b><br/>REHABILITATION AND AGED CARE</p> <p><b>RAILS Referral Form</b></p> | <p style="text-align: right;">URN: <input style="width: 100%;" type="text"/></p> <p>Surname: <input style="width: 90%;" type="text"/></p> <p>Forename: <input style="width: 90%;" type="text"/></p> <p>Gender: <input style="width: 15%;" type="text"/> DOB: <input style="width: 15%;" type="text"/></p> |
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| Referrer Details  | Patient Details  |
|---|--|
| <p>Name:</p> <p>Organisation: <input type="checkbox"/> OPH <input type="checkbox"/> GGH <input type="checkbox"/> JHC <input type="checkbox"/> Community</p> <p>Ward / Area:</p> <p>Discipline:</p> <p>Contact Details:</p> <p>Date:</p>   | <p>Contact Details:</p> <p>GP Details:</p> <p>DRAC Geriatrician:</p> |
| <p><b>Presenting Complaint / Principle Diagnosis:</b></p>   |  |
| <p><b>Relevant PMH:</b></p>   |  |
| <p><b>RAILS Input Required:</b>    <input type="checkbox"/> CN H/V    <input type="checkbox"/> CN Phone call    <input type="checkbox"/> OT    <input type="checkbox"/> PT    <input type="checkbox"/> SW</p> <p style="text-align: center; margin-top: 20px;">Please attach medication profiles, health, transfer and discharge summaries.</p>   |  |
| <p><b>Have the client / NOK given consent to RAILS intervention?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>   |  |
| <p><b>Are there any risks for home visiting?</b></p> <p><input type="checkbox"/> Violence    <input type="checkbox"/> Substance Abuse in Home    <input type="checkbox"/> Inappropriate Behaviour    <input type="checkbox"/> Aggression</p> <p><input type="checkbox"/> Aggressive Pets    <input type="checkbox"/> Infectious Diseases</p>  |  |
| <p><b>In what time frame would you like RAILS to respond?</b>    <input type="checkbox"/> 1-2 days    <input type="checkbox"/> 3-7 days    <input type="checkbox"/> &gt; 1 week</p>   |  |
| <p><b>RAILS Office Use</b></p>  |  |
| <p>Prevented hospital admission / readmission: <input type="checkbox"/>    Estimated OPH RAC Bed Days saved?</p> <p>Date Received:                      Date 1st Contact:                      Date D/C RAILS:                      Inappropriate Referral: <input type="checkbox"/></p> <p>Post D/C F/up: CN <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> SW <input type="checkbox"/>    Intervention on ward: CN <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> SW <input type="checkbox"/>    Community: CN <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> SW <input type="checkbox"/></p> |  |
| <p><b>Please contact the RAILS team with any queries</b></p> <p><b>T: 6457 8315    F: 6457 8263    M: 0404 803 569</b></p> <p><b>Healthlink ID: railsrt</b></p>   |  |

**RAILS REFERRAL FORM**

**MR(OPH) 66.9**