Medical Referral Form

REFERRAL TO

Date: _____ dd / mm / yyyy

Referral to: _____

Focal point: _____

Phone: _____

Email: _____

Location: _____

REFERRAL FROM

Referral from: _____

Focal point: _____

Phone: _____

Email: _____

Location: _____

PATIENT INFORMATION

First Name: _____

Last Name: _____

Date of birth: _____ dd / mm / yyyy

Gender

◯ Male ◯ Female

Phone number: _____

Address of discharge destination (if known):

Accompanied by care provider

◯ Yes ◯ No

Primary Diagnoses: _____

Other Diagnoses

Treatments Initiated

*Please attach copy of medication chart at discharge or list of current medications (including dose and time of last dose)

List of Medications

Reason for referral

◯ Inpatient ◯ Outpatient ◯ Community

Transportation needs: _____

Follow-up requirements: _____

FUNCTIONAL STATUS

Mobility

- [ ] Bed bound
- [ ] Wheelchair
- [ ] Crutches
- [ ] Walking frame
- [ ] Requires assistance
- [ ] Independent

Precautions: Such as weight bearing restrictions or spinal precautions:

Self-care

- [ ] Carer dependent
- [ ] Requires commode
- [ ] Requires modified latrine/washroom
- [ ] Independent

Cognitive impairment

- ◯ Yes
- ◯ No

Assistive devices(s) provided

Assistive device(s) required

Compiled by: _____ **Position:** _____

Signature

NOTE: This form must accompany the patient's medical file, and a copy of the form should be retained by the referring team.