REFERRAL FORM – Aged Care Assessment Team

Only completed forms will be accepted via email or post at:

- SJG Midland Referrals PO Box 268, Midland WA 6936
- MI.Referrals@sjog.org.au

Phone: (08) 946 24293 **Fax:** (08) 946 24085

ST JOHN OF GOD Midland Public Hospital

Operated by St John of God Health Care in partnership with the Government of Western Australia

Patient Details

URN Hospital No.		Title		Gender	
Surname		**First Name**		**D.O.B**	
Previous Name/s				Mobile	
Address				Phone	
Suburb & Post Code		Email			
Marital Status		Religion		**Medicare No.**	
Country of Birth		Interpreter?		**Reference No.**	
Indigenous Status		Language		**Expiry Date**	

Next of Kin/Carer

Relationship

Name

Address

Phone

Referrer Details

Usual GP? ☐ Yes ☐ No

Referrer Name **Provider No.**

Practice Name

Address

Suburb Post Code

Phone Fax

Reason for Referral (please tick one or more)

1. ☐ Medical Opinion **2.** ☐ Rehabilitation/Restorative Unit

3. Aged Care Day Therapy:

4. Home Care Packages: ☐ Level 1-2 ☐ Level 3-4

☐ Continence Clinic ☐ Parkinson's Clinic

5. ☐ Permanent Residential Care

☐ Falls Clinic ☐ Medical Clinic

6. ☐ Respite

☐ Memory Clinic - **Next of Kin**:_____

MOBILITY	MENTAL STATE	CONTINENT
1. ☐ Walks Alone **4.** ☐ Bed Bound	**1.** ☐ Normal **4.** ☐ Aggressive	**1.** ☐ Urine ☐ Yes ☐ No
2. ☐ Walks with Aid **5.** ☐ Wheelchair	**2.** ☐ Altered **5.** ☐ Depressed	**2.** ☐ Faeces ☐ Yes ☐ No
3. ☐ Walks with Assistance	**3.** ☐ Wanders Away	

Urgency ☐ P1 (30 days) ☐ P2 (90 days) ☐ P3 (365 days) Duration of Condition

Medical History/Main Diagnosis/Disabilities

*Please attach any relevant reports/results/history

Current Medications

Referring Doctor's Signature **Date**

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