Queensland Government

Geriatric, Adult Rehabilitation & Stroke Service *(GARSS)* Outpatient Referral Form

Facility: TOOWOOMBA HOSPITAL

(Affix identification label here)

URN:

Family name:

Given names:

Address:

Ph: (H) (M)

Date of birth: Sex: ☐ M ☐ F ☐ I

Referrer details *(NB Referral form must be completed in full or will be returned to referrer)*

Date of referral: Referrer name:

Provider number: Signature: Designation:

Organisation/address:

Phone no: Fax no:

If referring to Medical Clinics, Medical Consultant approved:

Consultant name: ***Signature:*** ***Provider no:***

Referral to ☐ Suitable for Telehealth

Medical Clinics – *Non-urgent, internal referrals are not accepted as per Hospital Policy. These should be directed to the GP.*

- ☐ Acute Tele-Geriatric Ward Round – Dr Basnayake *(use Tele-Geriatric Ward Round Referral and Assessment MR 50nc)*
- ☐ Fall Clinic – Dr Wijayaratne
- ☐ Geriatric Clinic – Dr Wijayaratne
- ☐ Hypertonicity Clinic – Dr Siu
- ☐ Memory Clinic – Dr Wijayaratne or Dr Basnayake
- ☐ Nursing Home Clinic – Dr Wijayaratne
- ☐ Parkinson's Clinic (65 and over) – Dr Gange
- ☐ Parkinson's Clinic (under 65) – Dr Siu
- ☐ Stroke Clinic – Dr Gange
- ☐ Telehealth Clinic – Dr Wijayaratne
- ☐ TIA Clinic – Dr Gange *(use Referral for Rapid Access TIA Clinic GARSS MR 50hd)*

Allied Health (Outpatient Rehabilitation)

- ☐ Advanced Allied Health Practitioner
- ☐ Occupational Therapy
- ☐ Pharmacy
- ☐ Physiotherapy
- ☐ Vestibular Rehabilitation
- ☐ Podiatry
- ☐ Psychology
- ☐ Social Work
- ☐ Speech Pathology

GARSS Inpatient Rehabilitation & GEMS *(use Referral to Inpatient Fast Stream Rehab/GEMS Program MR 50na)*

AGES *(use Internal Hospital Referral form MR 50h or Referral to HITNH Service MR 50oe)*

Client Details

Contact details *(if different from ID label):*

Next of Kin or contact person *(name)*: Relationship to client:

Phone number (H): (M):

Consent from client to make contact with Next of Kin/contact person? ☐ Yes ☐ No

☐ NDIS participant ☐ Identifies as A&TSI

GP Name: Address:

Current location of client: ☐ Home ☐ Hospital: ☐ Other:

If inpatient, expected discharge date: If TCP, expected discharge date:

Risks:

Is the client at immediate risk of harm *(e.g. falls, abuse, self-harm)* ☐ Yes ☐ No

Is the client at immediate risk of hospital admission? ☐ Yes ☐ No ☐ N/A

If 'Yes' to client risks, provide detail on page 2

Current community supports

☐ Home Care ☐ Meals on Wheels ☐ Day Respite ☐ Hygiene ☐ HCP 1, 2, 3, 4 *(circle)*

☐ Other: *(specify)* Providers:

Email completed form to: DDHHS_GARSS@health.qld.gov.au or FAX to 4616 5706 Phone: 4616 6692

MR 50n

GARSS Outpatient Referral Form

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Referral details

Situation

Reason for referral / presenting complaint / diagnosis / condition

Background

Medical history / relevant background / previous treatment / social history

Assessment

Why do they require GARSS follow-up?

Recommen-dations

Your suggestions about timeframes or clinical pathway (i.e. group class), include other referrals made ***(e.g. TCP, MAC, ACAT, Post acute)***

Client functional and cognitive ability

I = Independent, S = Supervision, A = Assistance	Pre-morbid level of function	Current level of function
Transfers		
Mobility *(include if aid used and type)*		
Self care		
Toileting/continence		
Dressing		
Household tasks		
Cognition *(e.g. MMSE, MOCA, Rudas or comment)*		
Mood *(e.g. HADS, DASS)*		
Communication		
Swallow		
Child or carer at risk		
Carer stress / distress		
Carer arrangements		
Medication		
Driving		

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