



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
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

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 5579 Phone: 4616 6692

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All clinical form creation and amendments must be conducted through Health Information Services.

v8.00 - 12/2018



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**Referral details**

<b>Situation</b>	Reason for referral / presenting complaint / diagnosis / condition
<b>Background</b>	Medical history / relevant background / previous treatment / social history
<b>Assessment</b>	Why do they require GARSS follow-up?
<b>Recommendations</b>	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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