health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:
MEDICAL AND ALLIED

Hillcrest Hospital
50 Hospital Road, Hillcrest
Tel: (031) 761 5899 Fax: (031) 765 3712
Email: **Arthi.premjith@kznhealth.gov.za** Or nonhlanhla.dlamini4@kznhealth.gov.za
www.kznhealth.gov.za

HILLCREST HOSPITAL

APPLICATION FORMS

(PLEASE COMPLETE ALL OF THE FORMS)

FOR COMPLETION BY REFERRING HOSPITAL

Name of referring hospital: .....

Postal address: ..... Code .....

Telephone No: (.....) ..... Name of social worker: .....

Patient's name: ..... Your reference: .....

Patient's present whereabouts: .....

Brief reason for application: .....

.....

DOCUMENTS ATTACHED: (Please tick appropriate items)

( ) Copy of patient's identity document
( ) Proof of all income, including patient's social pension document
( ) Proof of address

FOR USE BY HILLCREST HOSPITAL

QUERIES

Admin: .....

Nursing.....

Medical.....

APPROVAL

Admin Signature: ..... Date: .....

Nursing Signature: ..... Date: .....

Medical Signature: ..... Date: .....

ADMISSION ARRANGEMENTS

Transfer from:..... Admission Date:.....Ward.....

AUTHORISED BY: Signature..... Date.....

ACTUAL ADMISSION

Date admitted:..... Hospital No: ..... Ward: .....

Admitting officer: Signature:..... Date:.....

1 IDENTIFYING PARTICULARS

1.1: PERSONAL PARTICULARS OF PATIENT

Surname:..... ID Number:.....

First names:.....

Date of birth:..... Place of birth:..... Gender:.....

Marital status:..... Religion:..... Citizenship:.....

Home address:.....

..... Code.....

Referring Hospital:..... Ward:.....

1.2: PARTICULARS OF SPOUSE

Name:..... ID Number:.....

Residential address:.....

Postal address:..... Code.....

Telephone: Home(.....) .....Work(.....) .....Cell.....

1.3 NEXT OF KIN OTHER THAN SPOUSE:

Name:..... Relationship:.....

Address:.....

..... Code.....

Telephone: Home(.....) .....Work(.....) .....Cell.....

1.4 ANY OTHER CONTACT PERSON:

Name:..... Relationship:.....

Address:.....

..... Code.....

Telephone: Home(.....) .....Work(.....) .....Cell.....

2 SOCIAL WORKERS REPORT:

2.1 NAME OF PATIENT:.....

2.2 PERSONAL HISTORY OF PATIENT:

2.2.1 Relevant factors in early life:.....

.....

.....

2.2.2 Educational & occupational history:.....

.....

2.2.3 History of substance abuse:.....

.....

2.2.4 Current functioning:.....

.....

2.3: FAMILY CIRCUMSTANCES:

2.3.1 Family relationships:.....

.....

2.3.2 Ability to care for the patient:.....

.....

2.3.3 Housing & finances:.....

2.4 PATIENT'S FINANCES:.....

2.5 SUPPORT SYSTEMS AVAILABLE TO PATIENT:.....

.....

2.6 MOTIVATION FOR REHABILITATION SERVICE AT HILLCREST HOSPITAL:.....

.....

.....

2.7 ALTERNATIVES AVAILABLE IF APPLICATION IS NOT SUCCESSFUL:.....

.....

Name of Social Worker:..... Date:.....

Designation:..... Signature:.....

Hospital:..... Telephone number (.....) .....

Email: .....

4 MEDICAL REPORT:

FOR COMPLETION BY MEDICAL PRACTITIONER FROM REFERRING HOSPITAL

Patient's name:.....Age:.....Gender:.....

Hospital:..... Hospital Number:.....Ward:.....

Name of doctor:..... Tel: (.....).....

Diagnosis:.....

Date of admission:..... Duration of stay:.....

HISTORY:

1. The presenting complaints:.....

.....

2. History of previous illnesses / surgeries:.....

.....

3. Treatment history:.....

.....

4. Obstetric history & family history:.....

.....

5. Social history:.....

.....

6. Occupational history:.....

GENERAL PHYSICAL EXAMINATION:

1. Mental & emotional state:.....

.....

.....

2. a) Physical state (state defects).....

.....

2. b) Pressure sores (state number size & site).....

.....

If present state dressing use & frequency:.....

.....

3. Respiratory system:.....

4. Cardiovascular system:.....

Blood pressure (three readings).....

5. G. I. T:.....

6. C.N.S:.....

7. Genito-urinary system:.....

Is there incontinence?.....

Recent urine test result (or any other relevant investigations done).....

.....

8. X-ray report .....

.....

9. State if any infectious or contagious diseases:.....

10. Any other conditions not stated above:.....

.....

11. Current medication:.....

.....

12. General Comments:.....

.....

Signature:..... Date:.....

5 NURSING REPORT

FOR COMPLETION BY A REGISTERED NURSE

5.1 PATIENT'S PARTICULARS

Patient's surname: ..... Age: .....

First names: .....

Hospital: ..... Hospital no: ..... Ward: .....

Date of admission: ..... Diagnosis: .....

5.2 PRESENT TREATMENT

Medication: .....

Nursing care: .....

Specialised clinics: .....

5.3 SKIN

Intact | YES | NO |

Bedsores:

Number of bedsores: .....

Site/s of bedsores: .....

Size/s of bedsores: .....

Dressings:

Type and frequency of dressings: .....

Irrigation & frequency: .....

Rashes: ..... Allergies: .....

5.4 INDICATORS FOR CARE:

PLEASE TICK THE APPROPRIATE BOX	GOOD	FAIR	POOR
SIGHT			
HEARING			
ABILITY TO COMMUNICATE			
FACULTY FOR COMPREHENSION			
COMPLIANCE / COOPERATION			
MEMORY: SHORT TERM			

PLEASE TICK THE APPROPRIATE BOX	GOOD / INDEPENDENT	FAIR / NEEDS HELP	POOR / DEPENDENT
GROOMING			
DRESSING			
EATING			
WASHING			
BATHING			
TOILETING			

MOBILITY:

INDEPENDENT	STICK	TRIPOD	ZIMMER FRAME	WHEELCHAIR

MENTAL STATE:

ORIENTATED TO:	YES	NO
PERSON		
PLACE		
TIME		

INCONTINENCE

URINE	YES	NO	AT TIMES	NEEDS HELP
FAECES	YES	NO	AT TIMES	NEEDS HELP

CATHETER

NO	URETHRAL	SUPRA-PUBIC	SHEATH

Date last changed: ..... Size: .....

5.5 DIET:

FULL	SOFT	PUREE	DIABETIC	OTHER

ENTERAL / SPECIAL FEEDS

TYPE	FREQUENCY	AMOUNT

APPETITE:

GOOD	FAIR	POOR	OTHER

5.6 GENERAL REMARKS:

Physical limitations: .....

.....

Mental limitations: .....

.....

Behavioral problems: .....

.....

Nursing management: Pros:.....

Cons: .....

Signature: ..... Rank: .....

Name (print): ..... Date: .....

6 REHABILITATION REPORT

6.1 OCCUPATIONAL THERAPY REPORT

A. Patient Biographical Data & Background Info:

Name		AGE	
Hospital		IP Number	
DOA		Marital Status	
WARD		DOB	
Address			
Contact Person	Name: Relationship: Number:		

Presenting Condition and Onset:

_____

Medical History:

_____

Social History:

_____

Education history:

_____

Previous work history:

_____

B. Physical:

Muscle Strength	
ROM	
Hand Function	
Tone	
Balance	Sitting:
	Standing:
Pain	
Sensation	
Pressure Sores	
Oedema	
Posture	
Additional Comments	

C. Psychosocial:

Speech	
Orientation	
Attention and Concentration	
Motivation	
Additional Comments:	

D. ADLs:

	GOOD / INDEPENDENT	FAIR / NEEDS HELP	POOR / DEPENDENT	Comment
Grooming				
Dressing				
Eating				
Washing				
Bathing				
Toileting				
Transfers				
Additional Comments:				

E. Assistive Devices:

	YES	NO	Comment
Wheelchair			
Wheelchair tray			
Wheelchair cushion			
Lower limb splint			
Upper limb splint			
Other			

F. Constructive use of time:

_____
_____
_____

G. Recommendations:

_____
_____
_____
_____

Referring Therapist Particulars

Name (print)			
Email			
Phone			
Date:		Sign:	

6.2 SPEECH THERAPY REPORT

Case History

Name: _____ DOB: _____

Date of Admission: _____ Previous Episodes_____

Etiology: CVA: _____Trauma: _____Other_____

Mental Status: Alert_____ Dull_____

Cooperative_____ Uncooperative_____

Feeding/Swallowing Screening

URGENT DIFFICULTIES	**Y**	**N**
History of pneumonia or chest infection		
Current pneumonia or chest infection		
Sudden weight loss		
Coughing or choking during meals		
Breathing difficulty when eating/drinking		
No attempt to swallow or food pooling in mouth		
Wet/gurgly voice after swallowing		

Cognition

	Y	**N**
Does the patient struggle with long term memory?		
Is the patient orientated to time, place or person		

Language (Expressive and Receptive)

	Y	**N**
Can the patient follow commands?		
Is verbal communication affected?		
Does the patient struggle with finding words to express themselves?		
Does the patient attempt to use alternative means to communicate (gestures, facial expression?)		
Does the patient present with hearing or visual impairment?		

COMPILED BY: _____ DATE: _____

SIGNATURE: _____

CONTACT DETAILS: _____

6.3 PHYSIOTHERAPY REPORT

PATIENT DETAILS:

NAME :
AGE : GENDER:
REFERRING HOSPITAL :
DIAGNOSIS :

CHRONIC CONDITIONS / SPECIAL INVESTIGATIONS/ SURGERY:

_____

_____

SUBJECTIVE ASSESSMENT:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ASSESSMENT:

SPEECH: _____ COGNITIVE ABILITY: _____

CHEST: _____ SENSATION:

PRESENTATION:

_____

_____

_____

_____

_____

TONE:

	R	L
UL		
LL		

TRANSFERS: _____

LYING:

ROLLING:

_____

_____

LYING TO SITTING:

_____

_____

BALANCE	**STATIC**	**DYNAMIC**
SITTING		
STANDING		

GAIT:

_____

_____

_____

_____

ASSISTIVE DEVICE:

INDEPENDENCE LEVEL:

TREATMENT PLAN:

SHORT TERM GOAL	LONG TERM GOAL

TREATMENT:

_____

_____

_____

_____

PATIENT CATEGORY: (TICK A BLOCK BELOW)

ACTIVE REHABILITATIVE PATIENT (INDICATE IF PATIENT IS FOR SHORT OR LONG TERM REHABILITATION)	**PATIENT NOT FOR PHYSIOTHERAPY INTERVENTION** (REQUIRES NURSING CARE)

COMPLIED BY:

_____

SIGNATURE:

_____

DESIGNATION:

_____

Contact details:

_____

_____

_____

3. DECLARATION OF ASSETS (TO BE COMPLETED BY THE SOCIAL WORKER/FAMILY):

3.1 ASSETS

3.1.1 All financial investments of patient & spouse e.g. savings, fixed deposits, shares, unit trusts etc.

Description	Value	Monthly interest
.....	R.....	R.....
.....	R.....	R.....
.....	R.....	R.....

3.1.2 All fixed property owned by patient & staff e.g. house, flat, land etc.

Description	Value	Amount still owing
.....	R.....	R.....
.....	R.....	R.....
.....	R.....	R.....

3.1.3 All other assets owned by patient & spouse e.g. vehicles, furniture, jewelry etc

Total approximate value of all items under this category R.....

3.2 DECLARATION OF MONTHLY INCOME	PATIENT	SPOUSE
Total monthly income derived from investments in 6.1 above	R.....	R.....
Rent received from property owned in 6.2 above	R.....	R.....
Salaries and/or other remuneration from employment or business	R.....	R.....
Government social pensions and grants	R.....	R.....
Other pensions, annuities etc.	R.....	R.....
Any other income. Specify.....	R.....	R.....
TOTALS	R.....	R .....

3.3 DETAILS OF PATIENT'S GOVERNMENT SOCIAL PENSION OR GRANT (old age disability etc)

Reference No: ..... Where paid: .....

Account no (if deposited directly into banking account): .....

3.4 DETAILS OF MEDICAL AID OR OTHER MEDICAL BENEFIT OR ASSISTANCE FUND etc.

Name of medical aid: ..... membership no: .....

Address: ..... code.....

Telephone no: (.....)..... Will the medical aid pay the fees? .....

3.5 FUNERAL POLICY Number: ..... Company: .....

3.6 LATEST WILL LODGED WITH: .....

3.7 DECLARATION

I hereby make application for the above-named patient to be admitted to Hillcrest Hospital, and understand that the hospital authorities reserve the right to discharge any patient according to altered circumstances. I declare that, to the best of my knowledge, the above information is a true and complete record, and I undertake to notify the Hillcrest Hospital admitting office in writing of any changes. I understand that government social pensions and grants are not paid to patients while in Hillcrest Hospital.

Signature: ..... Relationship: ..... Date: .....