



Alliance Rehabilitation provides *intensive*, time based rehabilitation in the community. Rehabilitation programs are delivered by an experienced interdisciplinary team including physiotherapy, occupational therapy, exercise physiology, speech pathology, dietetics, diabetes education, psychology, neuropsychology and social work.

Centre based programs are offered across the Townsville Region including *weekly* outreach to Ayr, Charters Towers, Ingham (Cardwell), Magnetic Island and Palm Island and *fortnightly* to Richmond and Hughenden.

Referrals to the CBRS will be managed by **Townsville Hospital and Health Service** and triaged through a central referral hub. Please send referrals to: **Email: TSV-Medicine-Referrals@health.qld.gov.au** **Fax: (07) 4433 2501**

Common Indications for Referral

- **General Rehabilitation**
Intensive outpatient and home-based therapy for recovery after a health event or following significant de-conditioning
- **Post-surgical rehabilitation**
(Rehab after Surgery e.g. knee replacements)
Cognition, assistance with ADL's, linking with community services, malnutrition prevention
- **Occupational Therapy Driving Assessment**
Assessment of a participant's suitability and fitness to drive and facilitation of return to driving after illness or trauma
- **Stroke rehabilitation**
Intensive rehabilitation post stroke aimed at maximising long term outcomes
- **Cardiac rehabilitation (Palm Island)**
Provides participants with knowledge and self-management skills following a cardiac event
- **Chronic neurological rehabilitation**
Individualised programs for people with chronic and progressive conditions e.g. Parkinson's disease, MND, MS
- **Mobility**
Activities to facilitate people's community access and mobility e.g. wheelchair prescription
- **Hydrotherapy**
Gentle aquatic therapy programs focussed on regaining physical fitness and well-being and mobility
- **Bariatric weight management and mobility**
MDT approach to weight management and mobility for community access, social inclusion and long-term outcomes
- **Frail elderly program**
Falls Prevention, Swallowing and Malnutrition risk, Mobility and home safety
- **Smoking cessation**
Quitskills Brief Intervention program for tackling indigenous smoking

URN:	Phone (home):
Family name:	Phone (mobile):
Given name(s):	Address:
Date of birth:	Discharge address and contact details if different to above:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Medicare no:	Emergency Contact/NOK:

<input type="checkbox"/> Consent to referral: This referral has been discussed with the participant and/or their guardian, and they understand and agree with the referral being made.	Aboriginal/Torres Strait Islander Status: <input type="checkbox"/> N/A <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander
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Is this person involved with Office of Public Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does this person require support for communication (eg. aphasia / interpreter) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please mark any of the following that apply: My Aged Care <input type="checkbox"/> DVA Gold <input type="checkbox"/> Insurance/Compensation <input type="checkbox"/> NDIS <input type="checkbox"/>		
Rehabilitation goals of referral:		
<ul style="list-style-type: none"> • • • • • 		
Is this a driving assessment referral?		
<input type="checkbox"/> No > Continue to next section		
<input type="checkbox"/> Yes > You must complete the separate 'Referral for Driving Assessment' in addition to this referral Attached? <input type="checkbox"/> Yes		
Presenting health condition:		
Has there been deterioration in function? (Explain)		
Has there been a recent hospital admission? (Date/Reason/Length of stay)	Have you /will you send referrals to services other than Alliance Rehabilitation? (Please list)	Are there other services currently involved? Home care package <input type="checkbox"/> Private Allied Health <input type="checkbox"/> Community support i.e Kith and Kin <input type="checkbox"/> Other <input type="checkbox"/>
Medical Clearance: What level of physical demand is the person <u>medically safe</u> to work towards? (To be completed by a medical practitioner)		
*RPE – Borg's Rating of Perceived Exertion 0 – 10 scale.		
<input type="checkbox"/> Very low physical demand (e.g. working in sitting or lying, very light walking – *RPE ≤2)		
<input type="checkbox"/> Low physical demand (e.g. short walks or pushing, 3 x week – *RPE 3-4)		
<input type="checkbox"/> Moderate physical demand (e.g. Walk, wheel, swim or cycle leisurely, ≤1 hour, 3-5 X week – *RPE 5-6)		
<input type="checkbox"/> High physical demand (e.g. Walk, wheel, run/jog, swim, cycle briskly ≥ 1 hour, ≥ 5 X week – *RPE 7-8)		
Is the participant safe to participate in water based activities: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are there precautions / restrictions / limitations that need to be observed during the program? If Yes, please detail:		
Is the participant at a risk of falling? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Referrer Details:		
Name:		
Discipline:		
Address:		
Phone:		
Fax:		
Signature:		Date:

Please attach Health/Discharge Summary, Relevant Pathology