

## Rehabilitation in the Home (RITH) referral form

PATIENT DETAILS			
Name:	Next of kin name:		
Address on discharge:	Relationship:		
	Next of kin phone:		
Home address:	Hospital admission date:		
	Planned hospital discharge date:		
DOB:	Health fund:		
Phone:	Membership or claim number:		
Email:	Medicare number:		
REFERRER DETAILS			
Hospital:			
Referrer name:	Phone:		
Referrer role:	Email:		
FUNDER			
<input type="checkbox"/> Health Fund	<input type="checkbox"/> Hospital -- HCF No-Gap	<input type="checkbox"/> WorkCover	<input type="checkbox"/> Other
PATIENT'S MEDICAL DETAILS			
Primary diagnosis/surgical procedure/current Issues:	Safety alert/infection risks:		
PMHx:	Social support/living circumstances:		
Allergies:	<input type="checkbox"/> Treating consultant declares patient medically stable for hospital discharge to Vitalis RITH		
<input type="checkbox"/> N/A			
Treating doctor/surgeon:	<b>RAPT Score (HCF only)</b> (See overleaf for details) <input type="checkbox"/>		
Usual GP:			
SIGNATURE			
Signature:	Date:		



Please use this Risk Assessment and Prediction Tool to determine the appropriate score for your patient.

### Risk Assessment and Prediction Tool (RAPT)

Item	Value	Score
1. What is your age group?	50–65 years	2
	65–75 years	1
	> 75 years	0
2. Gender?	Male	2
	Female	1
3. How far, on average, can you walk? (a block is 200 m)	2 blocks or more (±rests)	2
	1–2 blocks (the shopping center)	1
	Housebound (most of the time)	0
4. Which gait aid do you use? (more often than not)	None	2
	Single point stick	1
	Crutches/frame	0
5. Do you use community supports? (home help, meals-on wheels, district nurse)	None or one per week	1
	Two or more per week	0
6. Will you live with someone who can care for you after your operation?	Yes	3
	No	0
<b>Your score</b>		<b>...../12</b>