GC Rehab

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Rehabilitation Medicine Physician

Inpatient Rehabilitation Referral Form

Referring site information

Referring hospital

Bed / ward number

Patient ID number

Admission date

Contact Person

Contact person's phone number

Patient Information

First name

Last name

Date of Birth

Medicare number

Medicare Reference Number

Medicare Expiry (MM/YYYY)

Patient phone number

Patient Email

Patient address

City

State

Postcode

Funding source

☐ Private Health Fund Health fund name _____ Policy No. _____

☐ DVA ☐ Workers Compensation ☐ Self-funded ☐ Other

Referral Information

☐ The patient is aware of the referral and agrees to be contacted

Reason for referral

Diagnosis

Patient goals

Current mobility

Past medical history

Referrer information

Title

☐ Ms ☐ Mrs ☐ Mr ☐ Dr ☐ A/Prof ☐ Prof ☐ Other

First Name

Last Name

Provider number

Specialty

I would like to be kept informed by

☐ Email ☐ Phone

Practice phone number

Practice name

Email Address

(Practice) Street Address

City

State

Postcode

If this referral is being completed by a registrar or intern, details of the referring consultant must be provided below

Consultant first name

Consultant last name

Consultant Provider Number

Submission of this referral does not automatically constitute acceptance of the referral. We will contact your patient, and you will be advised of the outcome.

Signature

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