

The Memorial Hospital

INPATIENT REHABILITATION REFERRAL FORM

Patient Details

Name

Address

Telephone D.O.B

Primary Language

Health Fund..... Number Level of Cover.....

Principal Diagnosis

Past Medical History

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Allergy

Medically Stable Yes No Comment

Professional Contact Details

Name of referrer

Profession.....

Telephone Fax

Signed Date

General Practitioner

Phone Fax

Rehabilitation Goals

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Physiotherapy Hydrotherapy Occupational Therapy Speech Pathology

Has this patient been a previous client of day rehabilitation? YES NO

Office Use Only

Programme Start Date

FAX TO 8366 3703 - ENQUIRIES: 8366 3864