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Day Rehabilitation Unit
Suite 1, Level 4, 457 Wickham Terrace
SPRING HILL QLD 4000
P: 07 3834 4285 F: 07 3834 4291
E: sawmh-dayrehab@uchealth.com.au

Day Rehabilitation Program Referral

PATIENT DETAILS:

Name: ____DOB: ____________________

Address: ____

Phone Home: ______________________________ Mobile: ___________________________

Email: ____

Private Health Cover: ☐ YES ☐ NO

Private Health Insurer: ____

Membership Number: ____

Workcover Number: ____

REFERRING SPECIALIST/GP: ___________________________ Referral Date: ______________

Provider Number: ____

Address: ____

Phone: ____________________________Signature:__________________________________

CLINICAL NOTES:

Diagnosis: ____

Date of Onset: ____

Relevant Previous Medical History:

____

____

Main Problems/Symptoms to be addressed through Day Rehabilitation Program:

1. ____

2. ____

3. ____

Referred to: Dr Wilbur Chan Dr Susan Graham Dr Fiona Harris Dr Hoa Lu Dr Polly Tsai

Thankyou for completing our referral form: a referring letter outlining condition and past medical history in more detail would also be greatly appreciated.

Please fax this form to: 3834 4291