



**INPATIENT REHABILITATION  
REFERRAL REQUEST**

Family Name: \_\_\_\_\_ MR/UR: \_\_\_\_\_  
Given names: \_\_\_\_\_  
Address: \_\_\_\_\_  
Postcode: \_\_\_\_\_ DOB: \_\_\_\_\_  
Doctor: \_\_\_\_\_

(or place Patient ID Label here)

PLEASE COMPLETE AND SEND TO **457 WICKHAM TERRACE, BRISBANE 4000** OR FAX **07 3834 4497**

**THE ABOVE NAMED PATIENT IS REFERRED FOR ASSESSMENT TO THE ST ANDREW'S WAR MEMORIAL  
HOSPITAL REHABILITATION PROGRAM**

**PLEASE INDICATE PREFERRED CONSULTANT:**

☐ DR P. AITKEN

☐ DR F. HARRIS

☐ DR H. LU

**DIAGNOSIS:**

**PAST MEDICAL HISTORY:**

**PREVIOUS LEVEL OF FUNCTION:**

**CURRENT LEVEL OF FUNCTION (MOBILITY / ADLs / TRANSFERS):**

**REFERRING DOCTOR:**

**PROVIDER NUMBER:**

**SIGNATURE:**

**DATE OF REFERRAL:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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