SA000530

UnitingCare

REFERRAL - INPATIENT REHABILITATION REQUEST

Surname: ..... MR/UR no.: .....

Given name(s): .....

Address: .....

Postcode: ..... DOB: .....

Doctor: .....

(OR AFFIX PATIENT IDENTIFICATION LABEL HERE)

Please complete and send to 457 Wickham Terrace, Brisbane 4000 or fax 07 3834 4497

The patient is referred for comprehensive assessment to the *St Andrew's War Memorial Hospital Rehabilitation Program.*

Please indicate preferred consultant: ☐ Dr M. Galbo ☐ Dr F. Harris ☐ Dr H. Lu

Patient given name(s):	Patient surname:	
DOB:	Health fund name:	Health fund number:

Diagnosis

Past Medical History

Previous Level of Function

Current Level of Function (Mobility/ADL's/Transfers)

Referring Doctor name:	Signature:	Provider number:	Date of referral:

BINDING MARGIN - DO NOT WRITE.

REFERRAL - INPATIENT REHABILITATION REQUEST 005.30