

Rehabilitation referral form

(Please fax to 07 3163 7339)

Patient Details

Name: Hospital/ward:.....

Address:

Home telephone: Mobile:

DOB: Date of referral: Date ready for rehab:

Referring Doctor/ Person: **Refer to:**

Address:

Home telephone:

Referral for: Inpatient rehabilitation

Day therapy program

Diagnosis:

Date of onset:

Infection control needs: Yes No Oxygen/suction needs: Yes No

Relevant previous medical history:

Main functional problems/symptoms to be addressed through a rehabilitation program:

1.....

2.....

3.....

Funding for Rehabilitation Program

Name of private health insurer:

Membership number:

Self funded: WorkCover:

Referral does not guarantee placement on the Rehabilitation Program. Confirmation that patient has been accepted on Rehabilitation Program is to be obtained prior to transfer being arranged.

Please **FAX** this form to the Nurse Manager (07 3163 7339)

For further information about the unit please telephone 07 3163 7338

or visit www.mater.org.au/rehab-brisbane