Eastern Suburbs Private Hospital

DAY REHABILITATION REFERRAL FORM

7 Dutruc Street
Randwick NSW 2031
*Telephone: **(02) 8383 7400***
*Fax: **(02) 8383 7499***

NAME: …… DATE OF BIRTH: ……

GENDER: ❑ Male ❑ Female OCCUPATION: …… PREVIOUS PATIENT AT ESPH: ❑ Yes ❑ No

ADDRESS: …… P/CODE: ……

PHONE: (H) …… (W) …… (Mob) ……

CONTACT PERSON: …… RELATIONSHIP: …… PH: ……

MEDICARE NO: …… ExpDate: …… PHARM BENEFIT NO: ……

HEALTH FUND/DVA: …… MEMB. NO: …… SCHEDULE/COLOUR: ……

IF DVA - PLEASE SEND COPY OF DVA CARD WITH REFERRAL FORM

W/C / CTP INSURER: …… CLAIM NO: ……

CONTACT NAME: …… CONTACT PH: ……

PENSIONER: ❑ No ❑ Yes PENSION No: ……

CURRENT DIAGNOSIS:

PRE-EXISTING CONDITIONS ***(Tick Appropriate)***

	No	Yes	Details
Infectious Risk	❑	❑	
HX of Multi-Resistant Organism	❑	❑	
Wounds or Skin Breaks	❑	❑	
Cardiovascular	❑	❑	
Respiratory	❑	❑	
Diabetes	❑	❑	
Epilepsy	❑	❑	

Cognitive:	❑	Alert	❑	Oriented	❑	Cooperative	❑	Dementia	❑	Other: ……
Mobility:	❑	Independent	❑	Stick	❑	Pick Up Frame	❑	Rollator	❑	Non-Weight Bearing
Incontinence:	❑	Bladder	❑	Bowel	❑	IDC				
Toileting:	❑	Independent	❑	Assisted						

NOTES:

THIS PATIENT IS PRESENTLY: ❑ **FIT** ❑ **UNFIT** **For Hydrotherapy**

Recent Hospitalisation: ❑ No ❑ Yes: Facility Name …… Discharge Date ……

Reason for Admission: ……,,,,,,

Medical/Surgical History: ……

Referring Doctor Name: …… ❑ GP ❑ Specialist Contact No: ……

Doctor's Signature: …… Date: ……

Referral Channel: ❑ Internet ❑ Prior Referral ❑ Liaison Officer ❑ Word Of Mouth

PLEASE SEND COMPLETED FORM VIA:

FAX: (02) 8383 7499 or

EMAIL: dayrehab@mhseastern.com.au