Day Program Referral Form

Patient Name:

Date of Birth:

MRN:

Stick patient label here

TO BE COMPLETED BY THE REFERRING HOSPITAL Further details may be required on preadmission assessment. The rehabilitation physician will assess suitability of proposed admission into the day program.	PLEASE FAX TO **8711 0255**

REFERRAL DATE:	REFERRING DOCTOR:	DISCHARGE DATE (if appropriate):
REFERRING HOSPITAL:	CONTACT NAME:	CONTACT NUMBER:

SECTION 1 PATIENT DETAILS

Surname		Given Names			
Title	Mr Mrs Ms Other	Date of Birth		Age	Sex M / F
Address					
Suburb		State		Postcode	
Ph (H)		Ph (W)		Ph (M)	

Aboriginal Torres Strait Islander Both Neither		Pension No.
Medicare No.	Exp:	Veterans No. White Gold
Language at Home		Health Fund
Contact No.		Health Fund No.
Next of Kin		GP (Family Doctor)
Relationship		GP Address

SECTION 2 FOR WORKERS COMPENSATION AND THIRD PARTY CLAIMS ONLY

Date of Accident	/ /	Claim No.
Insurance Company		Phone:
Contact person		Email:

SECTION 3 MEDICAL HISTORY

Current History :		**Allergies** ☐ Yes ☐ No Allergy /Reaction:
Past medical history:		

SECTION 4 FUNCTIONAL STATUS

Current Mobility Status	☐ Independent	☐ Supervised	☐ Assist	☐ Wheelchair
Current Transfers	☐ Independent	☐ Supervised	☐ Assist	☐ Lifter
Sit to Stand	☐ Independent	☐ Supervised	☐ Assist	☐ Lifter
Bed Mobility	☐ Independent	☐ Supervised	☐ Assist	☐ Lifter
Stairs	☐ Independent	☐ Supervised	☐ Assist	☐ Rails
Weight bearing Status	☐ Full Weight Bear	☐ Partial Weight Bear	☐ Touch Weight Bear	☐ Non Weight Bear
Hydrotherapy clearance	☐ Yes ☐ No	**Means of transport**		

SECTION 5 THERAPIES REQUIRED

Physiotherapy ☐ Yes	**Hydrotherapy** ☐ Yes
Hip/ Knee Group ☐ After ☐ sessions	**Exercise Physiology** ☐ Yes
Other ☐	**Occupational therapy** ☐ Yes
Unavailable Days:	**Balance Group** ☐

SECTION 6 DAY PROGRAM CO-ORDINATOR

Date referral received -	**Fund check status -**
Patient appointment scheduled ☐ Yes ☐ No	**Name -** **Sign -**