Westmead Rehabilitation Hospital

DAY PROGRAM REFERRAL FORM

PH: (02) 88 333 555 Fax: (02) 88 333 533
E: westmead@healthecare.com.au

Surname:	DOB: / /
Given Name:	☐ Male ☐ Female
Address:	
Referring Dr:	Fund:
Complete above or attach patient label	

Patient Details

Patient Name: Ph: (H) (M)

Referrer Details

Referrer Name: Sign: Date:

Referring Facility:

Specialist/GP/Surgeon:

Diagnosis and Disability

Work Cover/CTP: ❑ Yes ❑ No Case Manager Details:

Primary Diagnosis:

Relevant Medical History:

Current Status:

Rehabilitation Day Program Required (Please select a program OR at least 2 individual therapies)

Programs

❑ Parkinson's Program	❑ Cardiac Rehabilitation Program
❑ Lymphoedema Program	❑ Pain Program

Individual Therapies

❑ Physiotherapy ❑ Gym ❑ Knee Program (11am Mon-Thur) ❑ Recon Program (1pm Mon – Fri)	❑ Ex Physiology ❑ Circuit group (12:00pm or 12:30pm) ❑ Hydrotherapy
❑ Occupational Therapy	❑ Clinical Psychology
❑ Speech Therapy	❑ Dietitian

Reasons for Referral and Goals of Therapy

WESTMEAD REHABILITATION HOSPITAL STAFF USE ONLY

Transport required ❑ Yes ❑ No If YES then please tick one of the following:

❑ W/C and CTP	❑ Community Transport	❑ DVA transport	❑ Hospital Car
Session Frequency: (sessions per week – standard is 2)		Program Length: (number of weeks – standard is 4-6)	

Circle Days / Times that patient is UNAVAILABLE to attend: (Please encourage patients to be flexible with times)

Monday (AM / PM) Tuesday (AM / PM) Wednesday (AM / PM) Thursday (AM / PM) Friday (AM / PM)

Special Requirements (Please tick any/all that apply)

❑ CALD ❑ Poor cognition ❑ 1:1 INITIAL ❑ 1:1 ALL SESSIONS ❑ 1 x Assist for ADLs ❑ 30min slot

MR – 03 DAY PROGRAM REFERRAL FORM