Westmead Rehabilitation Hospital

Please complete and fax to Westmead Rehabilitation Hospital on 88 333 533 or email to westmead@healthecare.com.au

Affix Patient Label

N.B. All patient referrals will have their eligibility assessed according to the Rehabilitation Guidelines prior to acceptance onto the Day Program. The patient will be contacted directly with confirmation or alternatively offered Outpatient services.

☐ Day Program Referral ☐ Outpatient (Allied Health) ☐ Outpatient Hydrotherapy ☐ NDIS qualified

1. PATIENT DETAILS:

Patient's Name: _____ Tel: _____

2. REFERRER DETAILS:

Referrer's Name: _____ Signature: _____

Referring Facility: _____ Referrers Provider No.: _____

Address: _____ Date: _____

Specialist / Surgeon / GP: _____

3. DIAGNOSIS AND DISABILITY:

Primary Diagnosis: _____

Relevant Medical History: _____

_____

Current Status: _____

4. REASON FOR REFERRAL / GOALS OF THERAPY:

_____

_____

_____

5. TRANSPORT REQUIRED: ❑ Yes ❑ No

If Yes: ❑ DVA ❑ Workers' Comp / CTP Insurance ❑ Community Transport

***N.B. Transport only available for Day Program Eligible Patients**

WESTMEAD REHABILITATION STAFF USE ONLY

ELIGIBILITY ASSESSED AGAINST REHABILITATION GUIDELINES: ☐ Yes ☐ No

Assessed by: _____ ☐ Day Program ☐ Outpatient ☐ NDIS

DAY PROGRAM REHABILITATION REQUIRED:

☐ Orthopaedic Program ❑ Neuro Rehabilitation Program ❑ Reconditioning Program

OUTPATIENT REQUIREMENTS:

☐ Outpatient Hydrotherapy ☐ Outpatient Allied Health

ALLIED HEALTH DISCIPLINES REQUIRED:

❑ Physiotherapy ☐ Exercise Physiology ❑ Occupational Therapy
☐ Dietitian ☐ Social Worker ❑ Speech Therapy

Requested Session Frequency: _____ ***(ie number of sessions per week)***

Requested Program Length: _____ ***(ie number of weeks)*** Inpatient discharge date ***(if applicable)***: _____

Days / Times that patient is *unavailable* to attend:
(please circle or specify if required)

Mon	Tues	Wed	Thurs	Fri
am/pm	am/pm	am/pm	am/pm	am/pm

Notes: _____

SPECIAL REQUIREMENTS: ❑ Complex Needs ❑ Requires Initial ❑ Requires 1 on 1

MR-03 Day Program & Outpatient Referral Form