Rehabilitation Referral

Gold Coast PRIVATE HOSPITAL

REHABILITATION CONSULTANT

☐ Dr Michael Johnson ☐ Dr Chin Wong ☐ Dr Kean Ming Wong

☐ Dr Heshini De Silva ☐ Dr Jom Jiao

PATIENT DETAILS

NAME: ……………………………………………………………………………………………

DOB: ………./………./……… ☐ FEMALE ☐ MALE

ADDRESS: ……………………………………………………………………………………

PHONE: ………………………………………………………………………………………..

MEDICARE NUMBER: …………………………………… REF: …..…. EXPIRY: ………..

☐ Private ☐ DVA ☐ Work Cover ☐ Third Party ☐ Self-funded

Health Fund: ……………………………………… Membership No: ………………………..

SERVICES REQUESTED

☐ INPATIENT REHABILITATION ☐ DAY THERAPY REHABILITATION

REASON FOR REFERRAL

DIAGNOSIS FOR REHABILITATION: ……………………………………………………...

…………………………………………………………………………………………...…

REASON FOR MULTI-DISCIPLINARY TEAM INPUT: ……………………………………..

……………………………………………………………………………………………...

…………………………………………………………………………………………......

MEDICAL HISTORY (please attach separately)

REFERRING DOCTOR

Name: ………………………………………………… Provider No: ………………………..

Address: ……………………………………………………………………………………..

……………………………………………………… Phone: ……………………………..

Signature: ………………………………………………….. Date: ………/………/………

Please EMAIL to gcprehab@healthscope.com.au or FAX this form to 07 55 300 650

Alternatively, phone 07 55 300 125 for appointment and preparation advice.

Gold Coast Private Hospital

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