Cardiac Rehabilitation Referral

Gold Coast PRIVATE HOSPITAL by Healthscope

Patient Details

Name: ______ Date of birth: ______ ☐ FEMALE ☐ MALE

Address: ______

Phone number: ______

Medicare Number: ______

Ref: ______ Expiry date: ______

Health Fund: ______ Membership No: ______

☐ Private ☐ DVA ☐ Work Cover ☐ Third Party ☐ Self-funded DVA or Insurance Claim No: ______

Insurance Company Contact: ______ Insurance Company Phone: ______

Reason for Referral

Diagnosis:

Medical History (please attach Patient Health History and/or your letter 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. For further information please phone our Cardiac Rehabilitation Coordinator on 07 5530 0125.