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:

Services Requested

☐ Inpatient Rehabilitation ☐ Day Therapy Rehabilitation

Reason for Referral

Diagnosis for Rehabilitation:

Reason for Multi-Disciplinary Team Input:

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

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ABN 18 908 705 810 | V7 02/25