Rehabilitation Referral

Gold Coast PRIVATE HOSPITAL

REHABILITATION CONSULTANT

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

PATIENT DETAILS

NAME: .....

DOB: ...DD.../...MM.../...YYYY... ☐ 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

☐ Balance / Falls

☐ Back pain

☐ Osteoarthritis ..... e.g. Hip

☐ Reduced mobility / deconditioned

☐ Other: .....

.....

MEDICAL HISTORY (or attach separately)

REFERRING DOCTOR

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

Address: .....

..... Phone: .....

Signature: ..... Date: ...DD.../...MM.../...YYYY...

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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