Waratah Private Hospital

DAY REHABILITATION REFERRAL

FAX: 02 9598 0001 PHONE: 02 9598 0690
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Referral can be completed by Allied Health but must be signed by a Medical Practitioner

Surname.....
Given Names .....
D.O.B.....
Unit No..... Bed.....
Doctor .....

REFERRER INFORMATION (if Allied Health):	Name:	Designation:	Contact No:

HEALTH FUND INFORMATION: (if patient was previously admitted to WPH, leave blank)

CLAIM TYPE: ☐ Private Health Fund ☐ Workers Comp/CTP ☐ ADF/DVA ☐ Self-Insured

Health Fund/Insurer:	Membership/Claim No.:	Medicare No.:	Expiry: ____/____	Ref:

DIAGNOSIS/REASON FOR REHABILITATION (or attach referral letter)

PAST MEDICAL/SURGICAL HISTORY (or attach referral letter)

REHABILITATION GOALS:

Improved strength/fitness	☐	**ADDITIONAL GOALS:**
Improved joint mobility/flexibility	☐	
Increased functional independence with ADL's	☐	
Improved gait/mobility/balance	☐	
Improved pain management	☐	
Improve cognitive skills	☐	

REHABILITATION PROGRAM REQUESTED

☐ ORTHOPAEDIC ☐ LOW BACK PAIN ☐ RECONDITIONING (please circle: Post-Op / Cancer / General / Neurological / Cardiac)

THERAPIES REQUESTED

☐ PHYSIOTHERAPY ☐ HYDROTHERAPY* ☐ EXERCISE PHYSIOLOGY ☐ OCCUPATIONAL THERAPY ☐ DIETETICS

*If Hydrotherapy is requested, please ensure patient is medically cleared and, if applicable, Wound Management Plan is documented below as per surgeon preference.

WEIGHT-BEARING STATUS/PRECAUTIONS	
WOUNDS (include surgeon protocol if applicable)	
ALLERGIES/ALERTS/INFECTIOUS STATUS	

PATIENT REQUIREMENTS

Special Diet ☐ Yes ☐ No Details:_____

Requires interpreter ☐ Yes ☐ No Language: _____

Requires Carer to attend due to mobility or cognitive issues ☐ Yes ☐ No Name of Carer: _____

Referral Date: _____/_____/_____	**Referring Dr (GP/Specialist):**	**Signature:**

WPH ALLIED HEALTH USE ONLY

HEALTH FUND CHECK COMPLETED: ☐ Yes Result: _____

PROGRAM TYPE: ☐ Full Day ☐ Half Day Start Date: _____/_____/_____ Initial Program length: _____ sessions

Rehab Specialist:_____ Session Days/Times:_____

Confirmed by (name):_____ Designation: _____ Date: _____/_____/_____

BINDING MARGIN — DO NOT WRITE

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