Epworth

Unit Record Number .....
Surname .....
Given name .....
D.O.B. ..... Age ..... Sex.....
Medical Specialist .....

EPWORTH REHABILITATION REFERRAL FORM

Please *return* completed forms to:

Fax: 03 9982 6696

Email: rehab@epworth.org.au

☐ Inpatient ☐ Outpatient

Location

☐ Epworth Brighton ☐ Epworth Camberwell ☐ Epworth Geelong ☐ Epworth Hawthorn ☐ Epworth Richmond

Doctor

If a specific doctor is named, patients will be booked on their next available appointment.

Rehabilitation consultant: - or - ☐ Next available doctor

Patient Details

Surname: First Name: DOB:

Address:

Postcode:

Mobile: AH: BH:

☐ Uninsured ☐ Insured ☐ Compensable

Health Fund: Membership No.:

If a current inpatient, name of hospital:

Reason for Referral

Relevant Past History

* Please attach additional documentation including relevant medical history and investigations

Referring Doctor / Hospital

Name: Provider No.:

Address: Ward & Bed No.:

Telephone: Fax:

Email:

Signature: Date of Referral:

For any enquiries, please contact: **phone 1300 46 REHAB**
email rehab@epworth.org.au
fax 03 9982 6696

REF2R

04/17

EPWORTH REHABILITATION REFERRAL FORM REF2R