ST JOHN OF GOD
Berwick Hospital

REHAB REFERRAL FORM

U.R. Number .....

Surname .....

Given Names .....

Date of Birth ...../...../..... Sex .....

Use Label If Available

BW1700

Referral for SJOG:	☐ Berwick
Patient Requiring:	☐ Inpatient Rehab ☐ Outpatient Rehab

☐ **INPATIENT REFERRAL**

☐ **OUTPATIENT REFERRAL**

Rehab Unit Reception: (03) 8784 5468 Fax: (03) 8784 5528
Email: bw.ran@sjog.org.au
Phone: (03) 8784 5644 Fax: (03) 8784 5521
Email: BW.OutpatientRehab@sjog.org.au

Health Fund Details	Private Health Fund ☐ Name: ..... DVA ☐ TAC ☐ Workcover ☐
Membership / Claim number:	
Name of Patient's GP:	
Patient Location	☐ Hospital ..... Ward ..... Contact No: ..... ☐ Home
Assessment Date: (*Inpatient referrals*)	**Date Ready for Admission** (*Inpatient referrals*)
Principle Diagnosis Requiring Rehabilitation	
Surgery / Procedure	
Medical History	
Personal History	

Rehab Program						
	Neuro – Stroke	☐	Reconditioning	☐	Cardiac	☐
	Neuro – Non Stroke	☐	Pain	☐	Pulmonary	☐
	Ortho – Replacement	☐	Parkinson's	☐	Musculoskeletal	☐
	Ortho – Spinal	☐	Oncology	☐	Other	☐

Weight Bearing Status: ☐ NWB ☐ PWB ☐ TWB ☐ WBAT ☐ FWB

Referral Period: ☐ 3 Months ☐ 12 Months ☐ Indefinite:

Referring Doctor * ....
(*Signature*) (*Print Name*)

PROVIDER NUMBER: ..... Date: .....

REHAB REFERRAL FORM

MR 1700

SGHBKFMR1700 08/22