NP004C

INPATIENT/OUTPATIENT REFERRAL FORM

U.R. Number ....
Surname ....
Given Names ....
Date of Birth ....../....../......   Sex ....
Use Label If Available or BLOCK LETTERS

Referral for SJOG ☐ Frankston ☐ Bendigo ☐ Ballarat ☐ Warrnambool ☐ Geelong

Inpatient ☐ Phone 9788 3380 **Fax 9788 3304**

Outpatient ☐ Phone 9788 3367 **Fax 9788 3304**

Email: FN-admissions@sjog.org.au

NB: Outpatient referrals will not be processed without a doctors Signature & Provider Number

Referral Period 3 months ☐ 12 months ☐ indefinite ☐

Health Fund details	Private Health fund Name .... Number .... DVA ☐ TAC ☐ Workcover ☐ Claim number ....
Patient Location	☐ Hospital .... Ward .... Contact number .... ☐ Home Contact number ....

Admission date into acute _____ /_____ /_____   Ready for transfer date _____ /_____ /_____

NO WRITING IN MARGINS

Diagnosis

Rehabilitation program			
	Neuro ☐	Pain ☐	Reconditioning ☐
	Ortho ☐	Pulmonary ☐	Oncology ☐
	Spinal ☐	Musculoskeletal ☐	*MIP ☐

Referring doctors name ____

Person completing referral name ______________________ Signature ______________
Please print

Provider Number ______________ Date referral made _____ /_____ /_____

*MIP (Medical intervention program) is based on a sub-acute care model of chronic or complex conditions associated with ageing, chronic illness or disability.

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