NP004C

ST JOHN OF GOD
Frankston Rehabilitation Hospital

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 ☐ Ballarat ☐ Geelong ☐ Berwick

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 ____ /____ /____

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.

NO WRITING IN MARGINS

SGHFNFMR004C 07/21

INPATIENT / OUTPATIENT REFERRAL FORM

MR 004C