

ALLIED HEALTH REFERRAL Phone: 1800 854 300 Fax: 1800 854 611

Title: Patient's Surname: Given Name:

Patients Address:

Postcode: D.O.B: Ph: Mob:

Postal Address: (If different from above).....

Country of Birth: Medicare Number:.....

N.O.K: Relationship: Ph:.....

FUNDING: Health Fund: Membership Number:

DVA DVA Card Number DVA Gold DVA White

Self Funded Enhanced Primary Care (EPC) Other

Referring Doctor: Provider Number:..... Ph:.....

Referring Hospital: Admission Date: Discharge Date:

Hospital UR No: GP:..... Ph:.....

DIAGNOSES

Primary:

Secondary:.....

Past History:

Surgical Procedure (if applicable) Date: DRG:.....

Allergies:

TREATMENT REQUEST (tick appropriate boxes)

- | | |
|---|---|
| <input type="checkbox"/> Occupational Therapy Assessment | <input type="checkbox"/> Physiotherapy Assessment |
| <input type="checkbox"/> Home Safety Assessment | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Equipment prescription | <input type="checkbox"/> Exercise prescription |
| <input type="checkbox"/> Coordination of ongoing community supports | <input type="checkbox"/> Mobility assessment and retraining |
| <input type="checkbox"/> Other (specify) | |

SPECIFIC TREATMENT REQUEST

.....
.....
.....

Priority: High (1-2 Days) Medium (3-4 days) Low (5-7)

Known Function:

Existing Services: (please list)

Other Relevant Information/Hazards/Infections: (dogs, behavioural, MRSA etc.)

.....

Name of Referrer: **Referrer's Signature:**

Position: **Provider No:** **Date:**

ALLIED HEALTH REFERRAL

Phone: 8372 4999

Fax: 8372 4900

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