



Cairns Private Hospital

Part of Ramsay Health Care

REHABILITATION CENTRE REFERRAL FORM

MRN: _____

Surname: _____

Given Name: _____

DOB: _____ Sex: _____

(please affix Patient Identification label here, if available)

Patient Requiring: Inpatient Same day Outpatient (Sessional)

Health Fund Details:

Private Health Fund Name _____

DVA TAC Workcover

Membership / Claim Number:

Referring Hospital / Doctor:

Ward (If applicable):

Contact Name:

Telephone No.

Requested Date of Assessment: (Inpatient Only)

Date Ready for Admission: (Inpatient Only)

Diagnosis / Reason for Referral:

Date of Surgery/Procedure: (If applicable)

Relevant Medical History:

Social History: (Brief)

Rehabilitation Program:

Orthopaedic Upper Spinal Reconditioning

Orthopaedic Lower Other _____

Weight Bearing Status

NWB PWB TWB WBAT FWB

Referring Doctor _____ (Signature) _____ (Print Name)

Provider Number: _____ Date: _____

Rehabilitation Centre Phone number: 07 4052 8076 Rehabilitation Centre Fax number: 07 4052 5372

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BINDING MARGIN - DO NOT WRITE

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MR 3.10