RHC100.20
Referral/Consent

BINDING MARGIN - DO NOT WRITE

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**

REHABILITATION REFERRAL FORM

MR 3.10

Reset Form

Print completed Form

Email Completed form