RAMSAY HEALTH CARE

PORT MACQUARIE PRIVATE HOSPITAL

REHABILITATION DAY PROGRAM ASSESSMENT REFERRAL

Referral to:
(please ✓) ❑ Dr Roslyn Avery ❑ Dr _____
(Other Rehab Physician)

Please accept:

Patient's Full Name: _____

Patient's Address: _____

_____

Patient's Contact Phone Number(s): _____

Patient's Date of Birth: _____

Patient's Health Fund: _____

Health Fund Member Number: _____

Reason for day program assessment referral:

_____

_____

_____

_____

_____

_____

Referring Physician Details:

Dr's Name: _____

Dr's Signature: _____

Referral Date: _____

Please fax **completed referral** along with **medical history** and **medication list** to:

Rehabilitation Day Program Co-ordinator 02 6582 9861

PLEASE NOTE: All suitable candidates for day programs must be capable of independent mobility.

Office Use Only:
❑ HF Checked ❑ Reviewed by Day Program Co-ordinator ❑ Faxed to Rehab Physician on ____ / ____ / ____