Epworth

Unit Record Number .....
Surname .....
Given name .....
D.O.B. ..... Age ..... Sex.....
Medical Specialist .....

# EPWORTH REHABILITATION REFERRAL FORM

**Please *return* completed forms to:**

**Fax: 03 9982 6696**

**Email: rehab@epworth.org.au**

Clear form

☐ Inpatient ☐ Outpatient

**Location**

☐ Epworth Brighton ☐ Epworth Camberwell ☐ Epworth Geelong ☐ Epworth Hawthorn ☐ Epworth Richmond

**Doctor**

If a specific doctor is named, patients will be booked on their next available appointment.

Rehabilitation consultant: - or - ☐ Next available doctor

**Patient Details**

Surname: First Name: DOB:

Address:

Postcode:

Mobile: AH: BH:

☐ Uninsured ☐ Insured ☐ Compensable

Health Fund: Membership No.:

If a current inpatient, name of hospital:

**Reason for Referral**

**Relevant Past History**

* Please attach additional documentation including relevant medical history and investigations

**Referring Doctor / Hospital**

Name: Provider No.:

Address: Ward & Bed No.:

Telephone: Fax:

Email:

Signature: Date of Referral:

**For any enquiries, please contact: phone 1300 46 73422**
**email rehab@epworth.org.au**
**fax 03 9982 6696**

Complete and save this form to your computer and send via email as attachment to rehab@epworth.org.au

REF2R

04/17

EPWORTH REHABILITATION REFERRAL FORM REF2R