Royal Rehab
Private Petersham

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Day Program Referral form

Please fax to **(02) 9564 3064**

Patient name ______________________ **Date of birth** ___/___/___

Address ______________________

Phone ______________________

Referring specialist/GP ______________________ **Provider no.** ______________________

Hospital/Practice ______________________ **Contact no.** ______________________

Health fund ______________________ **Member no.** ______________________

CTP/WC ☐ **Claim no.** ______________________

Diagnosis ______________________

Reason for referral ______________________

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Goals ______________________

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Therapies required Select all that apply

- ☐ Physiotherapy
- ☐ Hydrotherapy
- ☐ PD Warrior
- ☐ Occupational Therapy
- ☐ Speech Pathology
- ☐ Dietetics
- ☐ Exercise Physiology
- ☐ Clinical Psychology

Program type

- ☐ **Orthopaedic**
- ☐ **Neurological** ☐ Stroke ☐ Non-Stroke
- ☐ **Reconditioning**

Frequency of sessions required per week ________ ☐ Full day (3hr) ☐ Half day (2hr) **Proposed start date** ___/___/___

☐ Hospital Discharge Summary attached

Form completed by

Signature ______________________ **Name** ______________________

Designation ______________________ **Date** ___/___/___

Office use only

Booked ☐ Yes ☐ No **Confirmed** ☐ Yes ☐ No

Attended ☐ Yes ☐ No **If 'No' why** ______________________

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FM PAT DO-01 (02.23)