ST VINCENTS HOSPITAL
SACRED HEART REHABILITATION

OUTPATIENT REFERRAL

PATIENT DETAILS

Name:__________________________________ **MRN:**_____________________

Address:________________________________ **DOB:**_____________________

_________________________________ **Gender:** ❒Male ❒Female

Phone: (h) _____________________ **(m)**_____________________

Contact Person: _____________________ **Relationship:** ________________

Phone: (h) __________________________ (m)__________________________

Diagnosis <u>(detailed referral letter MUST be attached):</u>

____

Therapies Required (can be one or a more):

❒ PHYSIOTHERAPY ❒ OCCUPATIONAL THERAPY ❒ CLINICAL PSYCHOLOGY

❒ SOCIAL WORK ❒ SPEECH PATHOLOGY ❒ NEUROPSYCHOLOGY

❒ DIETICIAN

REFERRER DETAILS

Referring Therapist ________________ **SHR D/C Date <u>or</u> Referral Date:** ____________

Referring Dr:
❒ Dr Faux ❒ Dr Wu ❒ Dr Sun ❒ Dr Brooke ❒ Dr Parker ❒ Dr Watanabe

PLEASE ENSURE YOU COMPLETE <u>ALL</u> OF THE ABOVE DETAILS

PLEASE ATTACH TO REFERRAL LETTER AND SEND TO:

1. **Allied Health Outpatients, Level 3 Sacred Heart Rehabilitation OR**
2. **Fax: 8382 9431 Attention "SHR outpatients"**

INTAKE MEETING USE ONLY

Patient Priority Level: ❒ 1 ❒ 2 ❒ 3

Date of Intake: __________________ Call record: ___________________________

Date Patient Contacted:_____________ __________________________

Letter sent: ❒ Yes ❒ No Date of 1st Appointment:_________________

Referral entered into Outpatient Database ❒ Yes ❒ No

Database Impairment Code: __________________ ❒ New admission ❒ Ongoing referral