

Rehabilitation Referral

Patient details

Name:	Date of birth:	Female	Male
Address:			
Phone number:			
Medicare Number:			
Ref:	Expiry date:		
Health Fund:	Membership No:		
Private	DVA	Work Cover	Third Party
Self-funded	DVA or Insurance Claim No:		
Insurance Company Contact:		Insurance Company Phone:	

Services requested

Inpatient Rehabilitation

Day Therapy Rehabilitation

Reason for referral

Diagnosis for Rehabilitation:

Reason for Multi-Disciplinary Team Input:

Medical history (please attach Patient Health History and/or your letter separately)

Referring doctor

Name:	Provider No:
Address:	
Phone:	
Signature:	Date:

Please send this form to gcprehab@mater.org.au or fax to 07 5530 0650. Alternatively, phone 07 5530 0125 for appointment and preparation advice.

 **Mater Private Hospital Gold Coast**
14 Hill Street, Southport QLD 4215

 **07 5530 0300**

mater.org.au