Cardiac Rehabilitation Referral

mater private hospital gold coast

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:

Reason for referral

Diagnosis for Rehabilitation:

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
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07 5530 0300
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