F3250

REFERRAL TO MATER PRIVATE HOSPITAL REDLAND REHABILITATION UNIT

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

- **Please send completed form to the Bed Manager, fax number (07) 3163 7296 or email MPHRBEDMANAGER@mater.org.au**
- Please send patients progress notes and medication charts with referral form (if applicable)
- Direct enquires about referrals or bed availability to the Bed Manager, phone (07) 3163 7276
- This referral does not guarantee placement in the Rehabilitation Program
- Confirmation that the patient has been accepted in the Rehabilitation Program is to be obtained prior to transfer being arranged

Patient Details

Given name(s):		Surname:		
URN:	Sex: ☐ Male ☐ Female ☐ Intersex		Date of birth:	
Address:		Suburb:	State:	Postcode:
Home phone:	Mobile phone:	Hospital:	Ward:	

Referral Details

Date of referral:	Date ready for rehab:	Referral to:	Referral for: ☐ Inpatient rehabilitation ☐ Day therapy program
Referring doctor's name:		Contact details:	

Previous rehabilitation admission: ☐ Yes ☐ No If *YES*, previous doctor's name:

Diagnosis:

Date of onset:	Height (cm):	Weight (kg):	Oxygen/suction needs: ☐ Yes ☐ No	Infection control needs: ☐ Yes ☐ No

Relevant previous medical history:

Alerts:

Main problems/symptoms to be addressed through the rehabilitation program:

1.

2.

3.

Rehabilitation program type:

☐ Day therapy ☐ Inpatient rehabilitation ☐ Lower limb ortho ☐ Upper limb ortho ☐ Neuro ☐ Reconditioning ☐ Pain management (chronic)

Funding for Rehabilitation Program

Health fund name:	Health fund number:	Self-funded:	WorkCover:

Clinician (print name):	Designation:	Signature:	Date:

Binding margin - do not write. Do not reproduce by photocopying.
All clinical form creation and amendments must be conducted through Health Records.

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