

REHABILITATION CONSULTANT

- Dr Michael Johnson Dr Chin Wong Dr Kean Ming Wong

PATIENT DETAILS

NAME:

DOB: **DD** / **MM** / **YYYY** FEMALE MALE

ADDRESS:

PHONE:

MEDICARE NUMBER: REF: EXPIRY:

- Private DVA Work Cover Third Party Self-funded

Health Fund: Membership No:

SERVICES REQUESTED

- INPATIENT REHABILITATION DAY THERAPY REHABILITATION

REASON FOR REFERRAL

- Balance / Falls
 Back pain
 Osteoarthritis e.g. Hip
 Reduced mobility / deconditioned
 Other:
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MEDICAL HISTORY (or attach separately)

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.....

REFERRING DOCTOR

Name: Provider No:

Address:

..... Phone:

Signature: Date: **DD** / **MM** / **YYYY**

**Please EMAIL to gcprehab@healthscope.com.au or FAX this form to 07 55 300 650
Alternatively, phone 07 55 300 125 for appointment and preparation advice.**