DAY PROGRAM
REFERRAL FORM

Please fax to (02) 9564 3064

MetroRehab HOSPITAL
275 Addison Road, Petersham NSW 2049
Phone: (02) 8585 4914

PATIENT NAME:	DOB:
ADDRESS:	
TELEPHONE NO:	
REFERRING SPECIALIST/GP:	DATE:
HOSPITAL:	CONTACT NUMBER:
HEALTH FUND:	MEMB NO:
CTP/WC ☐	CLAIM NO:
DIAGNOSIS:	
REASON FOR REFERRAL:	

PLEASE TICK THERAPIES REQUIRED:

☐ PHYSIOTHERAPY	☐ RECONDITIONING	☐ SPEECH PATHOLOGY
☐ EXERCISE THERAPY	☐ SOCIAL WORK	☐ DIETITIAN
☐ OCCUPATIONAL THERAPY	☐ COMMUNITY OUTING	☐ CLINICAL PSYCHOLOGY
☐ HYDROTHERAPY		

COMMENTS:	
FREQUENCY OF SESSIONS REQUIRED:	x week
FORM COMPLETED BY:	
SIGNATURE	NAME:
DESIGNATION:	CONTACT NUMBER:

Office use only

Booked ☐ Yes ☐ No Confirmed ☐ Yes ☐ No

Attended ☐ Yes ☐ No If 'No' why

BINDING MARGIN — DO NOT WRITE

FM Pat DO-01 DAY PROGRAM REFERRAL FORM (02.14)