MetroRehab
HOSPITAL

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

DAY PROGRAM
REFERRAL FORM

Please fax to (02) 9564 3064

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

PLEASE TICK THERAPIES REQUIRED:

- ☐ PHYSIOTHERAPY
- ☐ EXERCISE PHYSIOLOGY
- ☐ OCCUPATIONAL THERAPY
- ☐ HYDROTHERAPY
- ☐ SPEECH PATHOLOGY
- ☐ DIETITIAN
- ☐ CLINICAL PSYCHOLOGY
- ☐ PD WARRIOR

PROGRAM TYPE:

- ☐ ORTHOPAEDIC
- ☐ NEUROLOGICAL
- ☐ RECONDITIONING
- ☐ CANCER REHAB
- ☐ CARDIAC REHAB

FREQUENCY OF SESSIONS REQUIRED: x week

PROPOSED START DATE: _____/_____/_____

FORM COMPLETED BY:

SIGNATURE:	NAME:
DESIGNATION:	DATE:

Office use only

Booked ☐ Yes ☐ No Confirmed ☐ Yes ☐ No

Attended ☐ Yes ☐ No If 'No' why

BINDING MARGIN — DO NOT WRITE

DAY PROGRAM REFERRAL FORM (07.18)

FM Pat D0-01