HammondCare Champion Life

GREENWICH HOSPITAL
AMBULATORY REHABILITATION SERVICES REFERRAL FORM

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
DOB	M.O
ADDRESS	
LOCATION/ WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Refer to: *All referred patients will need to be assessed by a Medical Specialist prior to commencing any rehabilitation program*

☐ **Dr Fey-Ching Un**
Director of Rehabilitation Services

☐ **A/Prof Andrew Cole**
Chief Medical Officer (Lymphoedema Clinic)

☐ **Dr Purdy Lau**

☐ **Dr Baraa Kassim**

Please Select Services required:

Rehabilitation Ambulatory Services:

- ☐ Physiotherapy
- ☐ Exercise physiology
- ☐ Dietetics
- ☐ Occupational therapy
- ☐ Hydrotherapy
  (Please complete medical clearance form and attach Greenwich Hydrotherapy Medical Clearance)
- ☐ Clinical **p**sychology
- ☐ Speech pathology
- ☐ Lymphoedema clinic
- ☐ Social worker

Home Based Rehabilitation (HBRS)

- ☐ Physiotherapy
- ☐ Occupational therapy

Patient Information

Name Mr/Mrs/Ms/Dr: _____ DOB: _____

Address: _____

Patient Phone Number: _____ Mobile: _____

Emergency Contact Person: _____ Phone number: _____

Medicare Number: _____ DVA No: _____ DVA Card Colour: _____

Private Health Insurance: _____ Fund No: _____

Reason for Referral/Clinical Notes:

_____

_____

_____

_____

_____

Please attach the following with this referral:

- ☐ Patient Health Record
- ☐ Medication List
- ☐ Discharge Summary
- ☐ Pathology/Radiology
- ☐ Other: _____

Referring Specialist/ GP Details only:

Specialist/ GP Name: _____

Provider No: _____

Practice Address: _____

_____

Phone: _____ Fax: _____

Signature: _____ Date: _____

Please forward completed form and attachments to:

Greenwich Rehabilitation Ambulatory Service
Greenwich Hospital
97-115 River Road,
Greenwich NSW 2065

Phone: (02) 9903 8333 Fax: (02) 9903 8269

email: rehabadmin@hammond.com.au

BINDING MARGIN - NO WRITING

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