



**REHABILITATION AMBULATORY SERVICES
REFERRAL FROM**

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DOB	M.O	
ADDRESS		
LOCATION/ WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Please submit completed referral forms to:

Email: greenwichrehab@hammond.com.au

Fax: (02) 9903 8269

Patient Information (if patient label not available)

Name: _____ DOB: _____

Address: _____

Patient Phone Number: _____ Mobile: _____

Emergency Contact Person: _____ Phone number: _____

Medicare Number: _____ Private Health Insurer/DVA details: _____

Please select services required:

Clinic-based Ambulatory Rehabilitation Services:

- Rehabilitation Physician
- Occupational therapy
- Physiotherapy
- Clinical psychology
- Exercise physiology
- Speech Pathology
- Dietetics
- Lymphoedema clinic
- Hydrotherapy (fee-paying or via Private Health Insurance)

Home-Based Rehabilitation Services:

- Patient has SMART Home-Based Rehabilitation goals, and/or patient's circumstances prohibit them from attending clinic-based services.
- Physiotherapy
- Occupational therapy

Refer to a Rehabilitation Physician (if required):

Dr Fey-Ching Un

A/Prof Andrew Cole

SMART rehabilitation goals as discussed with patient:

Attached with this referral:

- Patient Health Record
- Medication List
- Discharge Summary
- Other: _____

Referrer details:

Name: _____

Provider No (if applicable): _____

Practice Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

Contact us:

Address:

Rehabilitation Ambulatory Services
HammondCare Pacific Centre
38 Pacific Highway
St Leonards NSW 2065

Phone:

Reception: (02) 9903 8333

Clinical Intake Line: 0467 505 646

Email: greenwichrehab@hammond.com.au

BINDING MARGIN - NO WRITING

GREENWICH HOSPITAL AMBULATORY REHABILITATION SERVICES REFERRAL FORM