DAY REHABILITATION
CANCER RELATED FATIGUE PROGRAM

REFERRAL FORM

Griffith Rehabilitation Hospital
13 Dunrobin Road, Hove SA 5048
Phone: 8179 4202 Fax: 8298 5520

Patient Name: _____ DOB: _____

Address: _____ Post Code: _____

Phone: Home: _____ Mob: _____ Medicare No: _____

Private Health Insurance: Name of Fund: _____ Member/DVA No: _____

Medicare No: _____ Expiry Date: _____

Referring Oncologist: _____ Provider No: _____

Phone: _____ Fax: _____ Date of Referral: _____

General Practitioner: _____ Provider No: _____

Address: _____ Phone: _____

Referral Details: *Please provide as complete information as possible or provide a discharge summary*

Diagnosis: _____

_____

Comorbidities: _____

_____

Treatments:

Surgery: _____

Chemotherapy (past and planned): _____

Radiotherapy (past and planned): _____

Is an infusaport in situ? ☐ Yes ☐ No **Appropriate for Hydrotherapy?** ☐ Yes ☐ No

Psychosocial:

Family / support: _____

Work: _____

Recreation: _____

Health:

ADL functional level: _____

Respiratory function: _____

Cardiac function: _____

Bladder: _____ Nausea: _____

Bowels: _____ Pain: _____

Observations: Resting HR: _____ Resting BP: _____

Hospital Use Only: Date referral received: _____ Date sent for Health Fund Check: _____

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