

Day Rehabilitation Referral

FOR GENERAL ENQUIRIES, PLEASE CONTACT US Phone: (08) 8179 4202

Program:

Orthopaedic	Neurological	Back Care/Spinal	Vehicle Injury
Reconditioning	Cancer/Oncology	Work Injury	Other

Patient Details:

Surname:	First Name:	Date of birth:	/	/
Address:		Postcode:		
Mobile:	Home Ph:			
Email:				
Health Fund:	Membership/Claim No:			
Medicare No:	Number on card:	Medicare Expiry:	/	

Diagnosis / Reason for referral: (Please attach additional information as required)

Contact Precautions (ie MRSA/VRE/ESBL)? If Yes, please contact prior to referring.

Patient appropriate for hydrotherapy? Yes No **Cleared to commence from:** / /

Relevant Past History: (Please provide current medication list)

Referring Doctor/Specialist: (AH or nursing referrals cannot be accepted)

Name:	Provider No:	
Address:		
Clinic Name:	Phone:	
Email:	Fax:	
Signature:	Date of Referral:	Date Received:

Griffith Rehabilitation Hospital

13 Dunrobin Road,
Hove SA 5048

[VER 1.0 Dec 2024/QC]

Email preferred

Please send this completed referral to:
grhdayrehab@healthscope.com.au

OR Fax: (08) 8298 5520

SUBMIT FORM

CLEAR FORM