



Referral/Consent RHC100:20



Masada Private Hospital
Part of Ramsay Health Care

MRN: _____

Surname: _____

Given Name: _____

D.O.B: _____ Sex: M F

(Affix Patient Identification label here)

The Bayside Rehabilitation Centre Referral Form

Patient Requiring: Inpatient Same day (Day Rehabilitation Program) Outpatient (RHP - self funded)

Health Fund Details: Private Health Fund Name: _____
 DVA TAC Workcover

Membership / Claim Number:

Referring Hospital / Doctor: _____ **Ward (if applicable):** _____

Contact Name: _____ **Telephone No:** _____

Requested Date of Assessment: _____ **Date Ready for Admission: (Inpatient Only)** _____

Diagnosis / Reason for Referral: (ie: Surgery/Procedure include date)

Relevant Medical History:

Social History: (Brief)

Rehabilitation Program: Orthopaedic Neurological Reconditioning Pain Management
 Cardiopulmonary Other: _____

Weight Bearing Status: NWB PWB TWB WBAT FWB

Referring Doctor:

Name: (print) _____ **Provider Number:** _____

Signature: _____ **Date:** _____

Rehabilitation Centre Phone number: 03 9038 1333 **Email:** RehabReferral.MSP@ramsayhealth.com.au

The information contained in the referral is confidential and may be legally privileged. It is intended for receipt only by the named addressee. If you are not the named addressee, any use, disclosure, copying or distribution of the referral or any of the information contained in it is prohibited. Please let us know if you have received this communication in error so we can arrange for it to be returned. Thank you.

BINDING MARGIN - DO NOT WRITE

REHABILITATION REFERRAL FORM

MR 006(a)