RHC100.20
Referral/Consent

BINDING MARGIN - DO NOT WRITE

Masada Private Hospital
Part of Ramsay Health Care

The Bayside Rehabilitation Centre Referral Form

MRN: _____

Surname: _____

Given Name: _____

D.O.B: _____ Sex: ☐ M ☐ F

(Affix Patient Identification label here)

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

REHABILITATION REFERRAL FORM

MR 006(a)

Reset Form

Email Completed Form