St Luke's HOSPITAL

Day Only Rehabilitation referral form

Patient Details

Full Name:	Patient Address:
Date of Birth:	Contact Telephone:

Health Fund ………………………………………… Membership Number ……………………...

Contact person ……………………………………….. ………………………………………………..
Name Relationship to patient

Contact Telephone ……………………………………

Referring Doctor ………………………………………………………………………………….
Name Contact or Provider Number

or ☐ Doctor's Referral Letter Attached

Diagnosis/ Reason for Referral:
including date of surgery if applicable

Mobility status:

Weight bearing: ☐ Full ☐ Partial WB ☐ Touch WB ☐ Non WB

Partial WB: ____________ Duration
Touch WB: ____________ Duration
Non WB: ____________ Duration

Cognitive State:

How does this patient comprehend and co-operate with therapy instructions ?
☐ Fully ☐ Somewhat ☐ Not very well ☐ Not at all

Recent Hospitalisation ☐ Yes ☐ No if Yes, Discharge Date: ……………………….

Please describe relevant medical history or other conditions affecting current care:

Bladder / bowel continence:

Usual living arrangements: ☐ Own home ☐ alone ☐ with relative/s
☐ Own home with carer support ☐ Hostel

Form completed by: .... **Date:**.............................
Please Print

Telephone Number: ………………………………………..

Fax to St Luke's Booking Office (02) 9357 2334

Telephone enquiries to Administrative Officer, Day Rehabilitation Unit (02) 9356 0224