ST JOHN OF GOD
Bendigo Hospital

REHABILITATION REFERRAL FORM

U.R. Number .....

Surname .....

Given Names .....

Date of Birth ...../...../..... Sex .....

Use Label If Available or BLOCK LETTERS

BE009

Patient Requiring: ☐ Inpatient Rehab ☐ Outpatient Rehab

Health Fund Details	Private Health Fund ☐ Name: ..... DVA ☐ TAC ☐ Workcover ☐
Membership / Claim number:	
Name of Patient's GP:	
Patient Location	☐ Hospital ..... Ward ..... Contact No: ..... Date of Admission ..... ☐ Community
Date of Current Admission	**Assessment Date:** **Date Ready for Admission**
Principle Diagnosis Requiring Rehabilitation	
Surgery / Procedure / Date	
Medical History / Complications	
Social History	
Expected Discharge Destination	

Weight Bearing Status: ☐ NWB ☐ PWB ☐ TWB ☐ WBAT ☐ FWB

Referring Doctor ....
(Signature) *(Print Name)*

PROVIDER NUMBER: ..... Date: .....

☐ **INPATIENT REFERRAL** **Phone: 0456 372 162**
Email: bendigorehab@sjog.org.au

☐ **OUTPATIENT REFERRAL** **Phone: 5434 3261** **Fax to: 5434 3380**
Email: alliedhealth.bendigo@sjog.org.au

NO WRITING IN MARGINS

REHABILITATION REFERRAL FORM

BE009

SGHBOFMR0009 01/24