The Wesley HOSPITAL
Caring for you for life

Wesley Allied Health: Outpatient Referral Request

Family Name: _____ MR/UR: _____
Given names: _____
Address: _____
Postcode: _____ DOB: _____
Doctor: _____

Email ALL Referrals to: Wesley-dayrehab@uchealth.com.au

Referring Doctor: _____ Referral Date: ____ I ____ I ____

Practice Details: _____

Doctor's Signature: _____

Patient Diagnosis: _____

_____

Past Medical History: _____

_____

_____

Symptoms or Functional Goals to be addressed through Outpatient or Day Rehabilitation Program:

1. _____
2. _____
3. _____

Date patient is ready to commence from: ____ I ____ I ____ ☐ URGENT

REFERRAL TYPE:

☐ **REHABILITATION (THERAPIES REQUIRED – TICK BELOW)**

☐ Physiotherapy ☐ Exercise Physiologist ☐ Occupational Therapy

☐ Speech Pathology ☐ Dietician ☐ Psychology

To assess eligibility for admitted programs please provide private health fund details if applicable.

Health Fund: _____

Fund Number: _____

Patient Name: _____

Patient DOB: _____

You have referred your patient to Outpatient Rehabilitation at the Wesley Hospital
Phone: (07) 3232 6190 Location: East Wing Level B1, TWH

FOR TWH ALLIED HEALTH ADMIN ONLY: Received: ____ I ____ I ____ BY _____