MacRehab

DAY

Rehabilitation Referral Form

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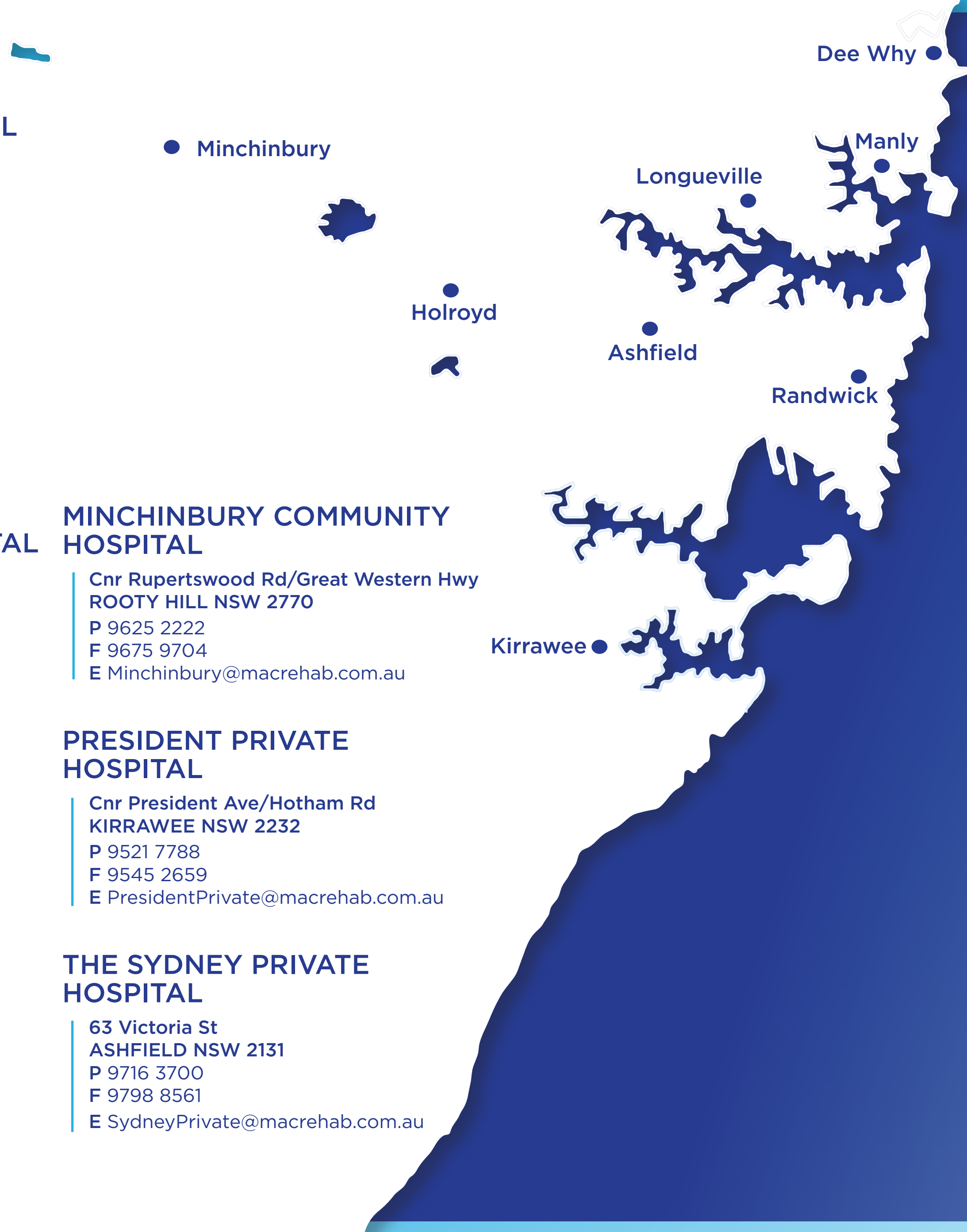
SYDNEY METROPOLITAN
REHABILITATION LOCATIONS



DELMAR PRIVATE HOSPITAL

58 Quirk St
DEE WHY NSW 2099
P 9982 7655
F 9971 7299
E Delmar@macrehab.com.au

EASTERN SUBURBS PRIVATE HOSPITAL

8 Chapel St
RANDWICK NSW 2031
P 9398 0800
F 9398 8472
E EasternSuburbs@macrehab.com.au

HOLROYD PRIVATE HOSPITAL

123 Chetwynd Rd
GUILFORD NSW 2161
P 9681 2222
F 9632 8480
E Holroyd@macrehab.com.au

LONGUEVILLE PRIVATE HOSPITAL

47 Kenneth St
LONGUEVILLE NSW 2066
P 9427 0844
F 9418 7329
E Longueville@macrehab.com.au

MANLY WATERS PRIVATE HOSPITAL

17 Cove Ave
MANLY NSW 2095
P 9977 9977
F 9977 4319
E ManlyWaters@macrehab.com.au

MINCHINBURY COMMUNITY HOSPITAL

Cnr Rupertswood Rd/Great Western Hwy
ROOTY HILL NSW 2770
P 9625 2222
F 9675 9704
E Minchinbury@macrehab.com.au

PRESIDENT PRIVATE HOSPITAL

Cnr President Ave/Hotham Rd
KIRRAWEE NSW 2232
P 9521 7788
F 9545 2659
E PresidentPrivate@macrehab.com.au

THE SYDNEY PRIVATE HOSPITAL

63 Victoria St
ASHFIELD NSW 2131
P 9716 3700
F 9798 8561
E SydneyPrivate@macrehab.com.au

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OUTPATIENT REHAB

Referral Form

Please PRINT clearly.
Fax/email to relevant facility.
To be completed by Specialist/ GP/Discharge Planner.

HOSPITAL STICKER

PROGRAM TYPE:

☐ ORTHOPAEDIC ☐ RECONDITIONING ☐ FALLS PREVENTION/BALANCE ☐ CARDIAC ☐ LYMPHOEDEMA
☐ NEUROLOGICAL ☐ PAIN MANAGEMENT ☐ RESPIRATORY ☐ METABOLIC ☐ OTHER: ______

GOALS: ______

HOSPITAL LOCATIONS:

☐ Delmar Private Hospital ☐ Holroyd Private Hospital ☐ Longueville Private Hospital ☐ Eastern Suburbs Private Hospital
☐ Manly Waters Private Hospital ☐ President Private Hospital ☐ The Sydney Private Hospital ☐ Minchinbury Community Hospital

PATIENT DETAILS:

Title: ____ Given names: ______ Surname: ______ Date of birth: ______ Weight (kg): ____ M ☐ F ☐
Address: ______ Home Ph: ______ Mobile: ______
Person responsible: ______ Contact No: ______ GP Name: ______ Contact No: ______
Health Fund/DVA/Insurance Name: ______ Membership/DVA No: ______
Medicare No: ______ Ref No: ______ Expiry: ______

CLINICAL DETAILS:

Reason for Referral: ______
Recent ACAT Assessment: ☐ Y ☐ N *Details:* ______
Relevant Medical History: ______
Current Medications: ______
Allergies: ______
Falls History: ______

Mobility:	*Bed mobility*	☐ Independent	☐ Supervision	☐ Assistance		
	Sit to Stand	☐ Independent	☐ Supervision	☐ Assistance		
	Ambulation	☐ Independent	☐ Supervision	☐ Assistance	☐ Crutches	☐ Rollator
		☐ W/Chair	☐ FASF	☐ PUF	☐ Stick/s	
Weight Bearing:		☐ Full	☐ Partial	☐ Touch	☐ As Tolerated	
		☐ Non weight-bearing weeks:				
Cognitive:		☐ Intact	☐ Confusion	☐ Delirium	☐ Dementia	
Hydrotherapy:		☐ Y	☐ N	*Commencement date:* ______		
Infection:		☐ Y	☐ N	*Details:* ______		
Usual Living Arrangements:		☐ Own Home	☐ Rents	☐ Hostel	☐ Nursing Home	
Lives:		☐ Alone	☐ W/Partner	☐ W/Relatives	☐ W/Carer	
Swallowing Intact:		☐ Yes	☐ No	☐ NGT/PEG		
Diet:		☐ Normal	☐ Diabetic	☐ Tube Feed	☐ Supplement: ______	

REFERRER'S DETAILS:

Referrer's Name: ______ Provider No.: ______ Signature: ______ Date: ______