Delmar
private hospital

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DAY REHABILITATION REFERRAL

BINDING MARGIN – DO NOT WRITE

CONTACT DETAILS

Name:	
Address:	
DOB:	Phone:
Next of Kin:	
Next of Kin Phone:	Relationship:

INSURANCE DETAILS

Health Fund:	Membership No:
Medicare No / ID:	Expiry:
Veteran Affairs No. ☐ Gold Card ☐ White Card	
Have you been a patient in Delmar Private Hospital before? ☐ YES ☐ NO	

DIAGNOSIS AND REASON FOR DAY REHABILITATION:

Date to commence hydrotherapy: ☐ Contraindicated
Past Medical History:
Any history of dementia / sudden loss of consciousness / blackouts? ☐ YES ☐ NO

MOBILITY STATUS:

Ambulates independently: ☐ YES ☐ NO	Uses assistant device: ☐ YES ☐ NO	Requires assistance: ☐ YES ☐ NO
Transfer independently: ☐ YES ☐ NO	Weight bearing status: ☐ Full ☐ Partial ☐ Touch	
Wounds:		
Continence: ☐ YES ☐ NO	Urine: ☐ YES ☐ NO	Faeces: ☐ YES ☐ NO

REFERRER DETAILS:

Transferring from other hospital? ☐ YES ☐ NO	Hospital Name:
Ward Name:	Contact Name:
Phone:	Fax:
Referring Doctor:	
Provider Number:	