The Memorial Hospital

Day Rehabilitation Referral Form

Fax: 08 8366 3466

☐ **Dr Anupam Gupta** / ☐ **Dr Chooi Lam**

Patient Details (or Sticker)

Name: .... DOB: .... / .... / ....

Address: ....

Phone: (M).. (H)...

Health Fund: .... Number: ....

Over 18 years: ☐ Yes ☐ No

Presenting Condition: ....

Reason For Presenting Condition: (eg. osteoarthritis as the reason for a TKR)

....

....

Past Medical History: ....

....

Doctor/Referrer Details

By signing this form, I hereby give medical clearance for this patient to commence their rehabilitation program and declare they are medically fit.

Doctor: ....

Phone: .... Fax: ....

Signed: .... Date: .... / .... / ....

Additional Referrer's Name: ....

Profession: ....

Phone: .... Fax: ....

Signed: .... Date: .... / .... / ....

Services Required / Additional Information

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....

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Appointment Date/Time

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