Memorial Rehabilitation & Wellness Centre

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

.....

.....

.....

Appointment Date/Time

.....