NP004C

NO WRITING IN MARGINS

ST JOHN OF GOD
Frankston Rehabilitation Hospital

INPATIENT / OUTPATIENT REFERRAL FORM

U.R. Number .....

Surname .....

Given Names .....

Date of Birth ...../...../..... Sex .....

Use Label If Available or BLOCK LETTERS

Referral for SJOG ☐ Frankston ☐ Ballarat ☐ Geelong ☐ Berwick

Inpatient ☐ Phone 9788 3380 **Fax 9788 3304**

Outpatient ☐ Phone 9788 3367 **Fax 9788 3304**

Email: FN-admissions@sjog.org.au

NB: Outpatient referrals will not be processed without a doctors Signature & Provider Number

Referral Period 3 months ☐ 12 months ☐ indefinite ☐

Health Fund details

Private Health fund Name .....

Number .....

DVA ☐ TAC ☐ Workcover ☐

Claim number .....

Patient Location

☐ Hospital ..... Ward .....

Contact number .....

☐ Home Contact number .....

Admission date into acute _____ /_____ /_____ Ready for transfer date _____ /_____ /_____

Diagnosis

Rehabilitation program

Neuro ☐	Pain ☐	Reconditioning ☐
Ortho ☐	Pulmonary ☐	Oncology ☐
Spinal ☐	Musculoskeletal ☐	*MIP ☐

Referring doctors name _____

Person completing referral name _____ Signature _____

Please print

Provider Number _____ Date referral made _____ /_____ /_____

*MIP (Medical intervention program) is based on a sub-acute care model of chronic or complex conditions associated with ageing, chronic illness or disability.

SGHFNFMR004C 07/21

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