Outpatient Referral

North Eastern Rehabilitation Centre

Dear Doctor, thank you for assessing the following patient.

Surname:	First name:	
Address:		
DOB:	☐ Male ☐ Female	
Phone (Home):	Phone (Work):	Mobile:
Health Fund/Insurer:	Claim No:	

Reason for Referral:

Inpatient discharge date:

Medical History:

Referral to:

☐ Physiotherapy	☐ Psychology	☐ Dietitian
☐ Hydrotherapy	☐ Occupational Therapy	☐ Social Work
☐ Speech Pathology	☐ Exercise Physiology	

Program

☐ Falls and Balance	☐ Healthy Lifestyle - Reconditioning	☐ Living Well with Parkinson's
☐ Cardiac Rehabilitation	☐ Joint Group	

Referral From:

Doctor:	Provider No:
Address:	
Phone:	Fax:
Signature:	Date:

Please see attached relevant reports, investigations and discharge summary

Please send referral form to: nerc.outpatientgroupreferral@healthscope.com.au

134 Ford Street, Ivanhoe VIC 3079
Phone: 03 9474 8900 | Fax: 03 9499 9341 | www.northeasternrehabilitationcentre.com.au
ABN 85 006 405 152 | A Healthscope hospital.