Outpatient Referral

The Victorian Rehabilitation Centre

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

REASON FOR REFERRAL:

MEDICAL HISTORY:

REFERRAL TO:		
Individual		
☐ Physiotherapy	☐ Occupational Therapy	☐ Social Work
☐ Hydrotherapy	☐ Psychology	☐ Dietetics
☐ Exercise Physiology	☐ Speech Pathology	
Program		
☐ Better Balance	☐ Hand Therapy	☐ Reconditioning
☐ Pulmonary Rehabilitation	☐ Pain Management	☐ Driving Assessment
☐ Joint Replacement	☐ Oncology	☐ Cardiac Rehabilitation

REFERRAL FORM:	
Dr:	Provider No:
Address:	
Phone:	Fax:
Signature:	Date:

Please attached relevant reports or investigations.

499 Springvale Road, Glen Waverley 3150
Phone: 03 9566 2777 | Fax: 03 9566 2749 | www.vicrehab.com.au
ABN 61 069 962 698 | A Healthscope hospital.