Outpatient Referral

The Victorian Rehabilitation Centre

Referral for:

Referral Fax: 03 9566 2749

Surname: _____ First Name: _____

Address: _____

_____

DOB: _____ ☐ Male ☐ Female

Phone (Home): _____ 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 from:

Dr: _____ Provider No: _____

Address: _____

_____

Phone: _____ Fax: _____

Signature: _____ Date: _____

Please attach relevant reports or investigations.

499 Springvale Road, Glen Waverley VIC 3150
Phone: 03 9566 2777 | Fax: 03 9566 2749 | www.vicrehab.com.au

ABN 61 069 962 698 | A Healthscope hospital.