Rehabilitation Clinics

General & Treatment Referral Form

Patient details

Name: **DOB:** **NHI number:**

Address: **Contact Phone:** **Gender: Male / Female / Diverse**

E-mail Address:

ACC INFORMATION (if applicable)

ACC Number: **Date of Injury:**

ACC Purchase Order Number: **ACC Case Manager:** **ACC E-mail address:**

GP Name:

GP Contact (e-mail preferred):

Referrer details

Name: Place of work: Address:

Phone: E-mail:

Clinical Information:

Reason for referral:

Clinical History:

Relevant medical history: (including etiology; recent procedures; recent investigations; dates)

Please attach relevant clinical letters or investigation reports.

Previous SLT History (including input) ***Please attach applicable reports***

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Previous Instrumental and specialist assessments: (Please include applicable studies/reports)

Please note: This is an outpatient clinic with swallowing specialists (SLTs). No medical specialists are on-site.

Referrer signature: **Date:**
