

IHD020

PATIENT REFERRAL FORM



Patient Sticker

Intercare Hazeldean Physical Rehabilitation Hospital

Practice No: 049 003 0472964

Tel. 012 880 0700

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Intercare Irene Physical Rehabilitation Hospital

Practice No: 049 003 0492256

Tel. 012 941 2600

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Intercare Newlands Physical Rehabilitation Hospital

Practice No: 999 059 0001264575

Tel. 021 891 0911

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Intercare Sandton Physical Rehabilitation Hospital

Practice No: 049 003 0724556

Tel. 010 880 1600

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Intercare Tyger Valley Physical Rehabilitation Hospital

Practice No: 049 003 0267791

Tel. 021 943 9800

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PERSONAL DETAILS: (THE COMPLETION OF THIS SECTION IS COMPULSORY)

Date:	Hospital:	Ward & bed nr:	
Patient name and surname:			
Date of birth/ID number:			
Medical Aid:		Medical Aid number:	

MEDICAL INFORMATION: (THE REFERRINGS SPECIALST/DOCTOR MUST COMPLETE THIS SECTION)

Referring Doctor 1:		Practice nr:	
Referring Doctor 2:		Practice nr:	

DIAGNOSIS AND ICD10 CODES

No	Diagnosis	ICD10 Code	No	Co-Morbidities	ICD10 Code
1			1		
2			2		
3			3		
4			4		
5			5		

PATIENT MEDICAL CONDITION AND REQUIREMENTS: *Current condition*

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MOTIVATION FOR TRANSFER AND TREATMENT PLAN:

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PLEASE SELECT THERAPY REQUIRED BY PATIENT:

Occupational Therapist	<input type="checkbox"/>	Speech Therapist	<input type="checkbox"/>	Wound Care	<input type="checkbox"/>
Physiotherapist	<input type="checkbox"/>	Social Worker	<input type="checkbox"/>	IV Therapy	<input type="checkbox"/>
Cardiac Observation	<input type="checkbox"/>	Other	<input type="checkbox"/>		

Name of person completing the form:		Rank:	
Signature:			