

**HOSPITAL AUTHORITY
REHABAIID & ROTARY REHABAIID CENTRES
PATIENT REFERRAL FORM**

**(Applicable to All Hospital, Out-patients Clinics
Department of Health or Any Private Health Care Service)**

REFERRING AGENT INFORMATION

Hospital Authority Institution YES NO

Referral Agency: _____

Address: _____

Name of Referrer: _____ Telephone number: _____

Post/Department: _____ Facsimile number: _____

PATIENT INFORMATION

Name of Patient (Chinese): _____ (English) _____

Sex/Age: _____ Birth Date: _____ H.K.I.D. No.: _____

Address: _____

Tel. No.: _____ Contact Person (if applicable): _____

Current Rehabilitation Service Being Received: _____

Specialty of Medical Service : _____

Diagnosis & Brief Medical History: _____

SERVICE REQUIRED

Specialty Service Required:

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Wheelchair Assessment & Training | <input type="checkbox"/> Computer Access | <input type="checkbox"/> Driver Rehabilitation | <input type="checkbox"/> Cognitive Rehabilitation | <input type="checkbox"/> Environmental Advisory Service (Architectural Consultation) |
| <input type="checkbox"/> Pressure Care | <input type="checkbox"/> Back Care | <input type="checkbox"/> Sexual Rehabilitation | <input type="checkbox"/> Service for Children with Developmental Coordination Disorder | <input type="checkbox"/> Wellness Enhancement |
| <input type="checkbox"/> Post-Concussion Syndrome | | | | |
| <input type="checkbox"/> Disability Coping Counseling | <input type="checkbox"/> Fall Prevention and Bone Mineral Density Enhancement | | | <input type="checkbox"/> Community-Based Chronic Pain Management |

Other Service Required:

Referral Objective:

ENDORSEMENT BY MEDICAL PRACTITIONER

Name of Medical Practitioner: _____ Telephone number: _____

Post/Department: _____ Facsimile number: _____

Signature of Medical Practitioner : _____ Date : _____

*Please attach a supplementary sheet if the space provided is insufficient.

Please fax this form to : Rehabaid Centre: 2764 5038 for adult patients, Rotary Rehabaid Centre: 2819 8041 for children patients
For enquiry, please phone : 2364 2345 (Rehabaid Centre) or 2817 5196 (Rotary Rehabaid Centre)

REHABAID PATIENT SERVICE

NOTES FOR REFERRERS

**(Applicable to all hospital patients, out-patients clinics
Department of Health or any private healthy care service)**

Our patient service covers wheelchair assessment and training, pressure care, back care, computer access, cognitive rehabilitation, driver rehabilitation, sexual rehabilitation, environment access, enhancement programme for employment of people with disabilities and rehabilitation of children with developmental coordination disorder.

Our rehabilitation professional team consists of occupational therapists, physiotherapist and architects.

Please note that:

Referral from a medical practitioner is preferred. If this is not possible, referral from any other health care professionals should be endorsed by the attending medical practitioner. Such requirement will facilitate our clinicians to maintain close communication with the medical practitioner who can advise us on the patient's diagnosis, recovery progress, prognosis, roles of other members in the team and specific rehabilitation goals for the patient. We believe that promoting communication between the related professionals can serve the best interest for patients receiving medical rehabilitation.

A **service acknowledgement letter** will be sent from Rehabaid to the referer and the medical practitioner within 2 weeks of the primary intervention.

A **discharge summary** will be sent from Rehabaid to the referer and the medical practitioner within 2 weeks after discharge.