IHD020	PATIENT REFERRAL FORM	Intercare Leaders in Health

Intercare Somerset West Physical Rehabilitation Hospital
Email: physicalrh.sw@intercare.co.za Tel. 021 892 2220

Patient Sticker

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*

MOTIVATION FOR TRANSFER AND TREATMENT PLAN:

PLEASE SELECT THERAPY REQUIRED BY PATIENT:

Occupational Therapist	☐	Speech Therapist	☐	Wound Care	☐
Physiotherapist	☐	Social Worker	☐	IV Therapy	☐
Cardiac Observation	☐	Other	☐		

Name of person completing the form:		Rank:	
Signature:			