Government of Western Australia
East Metropolitan Health Service

Rehabilitation Engineering Clinic
Health Technology Management Unit
State Rehabilitation Centre – Level 2
20 Fiona Wood Road, MURDOCH WA 6150
T: 08 6152 7047
Fax: 08 6152 9762

REFERRAL FOR REHABILITATION ENGINEERING CLINICAL SERVICES

DATE:_____

Send Referral via eReferral or email to FSH.Referrals@health.wa.gov.au.

Billing Information

Who will fund the service (e.g: NDIS, CAEP):			
Reference number (e.g ICWA crash number / NDIS reference number):			
Mailing Address			
Suburb		**Postcode**	
Email Address for invoice:			
Contact Name:			
Telephone Number:			

Please note that REC may not be able to process the referral without adequate billing information, for any questions please contact us.

CLIENT DETAILS

CLIENT NAME:	UMRN:
ADDRESS: POSTCODE:	
DATE OF BIRTH:	TELEPHONE:
HEIGHT:	WEIGHT:
SOCIAL SITUATION:	

MEDICAL DETAILS

DIAGNOSIS:	
PAST MEDICAL HISTORY:	IMPAIRMENT / DISABILITY: (List)

☐ Pressure management
☐ Manual wheelchair assessment and provision
☐ Electric wheelchair assessment and provision
☐ Specialised seating / postural support
☐ Other (please specify):_____

SPECIFIC GOALS FOR EQUIPMENT PROVISION:

WHY IS THE ITEM REQUIRED / WHAT ARE THE CURRENT PROBLEMS

WHAT OTHER OPTIONS HAVE BEEN CONSIDERED:

OPTIONS	OUTCOMES (problems, success or failure)

FACTORS WHICH WILL INFLUENCE PRESCRIPTION:

Please provide a SUMMARY to indicate current status, intervention to date and future plans

Existing mobility equipment (Wheelchair model, cushion, postural supports etc.)	
FUNCTIONAL AREA	SUMMARY
Home and Community Environment	
Self Care	
Prerequisite Skills (This may include review of posture, upper limb, cognition)	
Other Comments	

IDENTIFIED RISKS	
Risk factors for appointments within clinic or a home visit (eg. Substance abuse, smoker, pets)	

REFERRER DETAILS	
NAME:	
POSITION:	
ORGANISATION:	
PHONE:	**FAX:**
EMAIL :	