REFERRAL FORM

Please complete referral form and fax to head office on 03 8414 2816. We will contact the patient for an appointment and report assessment findings to the referrer.

Date of referral: / /

Best practice location (please tick Advance Online for patients outside of Victoria):

☐ Boronia ☐ Bundoora ☐ Clyde North ☐ Dandenong
☐ Geelong ☐ Hoppers Crossing ☐ St Albans ☐ Advance Online

Referrer Details (stamp if available)

Name:
Address:
Provider number:
Phone:
Fax:
Email:

Client details

Title: Family name:
Gender: Given names:
DOB: Home phone: Mobile phone:
Address:
E-mail:
Agent (TAC or W/C):
Claim number:
Date of injury:
Nature of the problem:

Investigations: *(please attach)* ☐ MRI ☐ CT ☐ Ultrasound ☐ X-ray ☐ Other

Treatment to date: ☐ Physiotherapy ☐ Surgery ☐ Other medical specialists
☐ Psychology ☐ Other (please describe) ……

Work status: ☐ Off work ☐ Seeking new job ☐ Modified work
☐ Not working by choice (student, retired, homemaker)

Preferred practitioner:

Preferred management:

☐ Multi-disciplinary pain management ☐ Pain specialist doctor ☐ Psychology
☐ Expert physio back pain assessment ☐ Physiotherapy ☐ Sports physio
☐ Other (please describe below) ☐ Worksite assessment ☐ Hydrotherapy