OLYMPIC PARK
SPORTS MEDICINE CENTRE

For all Appointments: 1300 859 887
Fax: (03) 9420 4352
www.opsmc.com.au

REFERRAL FOR TREATMENT

To: .... Date of Referral: .... / .... /...........

PATIENT DETAILS

Mr Mrs Master Miss Ms Dr Prof Other (circle) DOB .... / .... / ....

Surname: .... Given Name: ....

Address: ....

Suburb: .... Postcode: ....

Phone: (Home): .... (Work): .... (Mobile): ....

PROVISIONAL DIAGNOSIS: ....

....

....

History: ....

....

....

....

SERVICES REQUESTED ***[Consult our website www.opsmc.com.au for the list of procedures and diagnostic tests available at OPSMC]***

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Medication: ....

....

Allergies: ....

If Female: Pregnant: Yes / No (please circle) Breast Feeding: Yes / No (please circle)

REFERRING PRACTITIONER

Name: ....

Provider Number: (Medical Practitioners Only) ....

Address: ....

Phone: .... Fax: ....

Clinic Name: ....

Duration of Referral: 3 Months 12 Months Indefinite

Signature: ....