

in hand
occupational
therapy

Patient Referral

Patient Name Date of Birth

Address

Telephone

Private Health Cover? (Please Circle) Yes No

Membership Number

W/C MVIT

Claim Number

Diagnosis

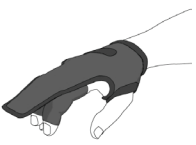
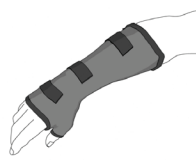
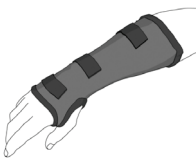
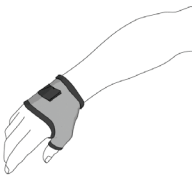
Treatment

Splint Required

Precautions / Special Instructions

Surgical Specialist On Referral Required? Yes No

Referring Doctor Date



Claremont

Unit 4, 44 Barnfield Road
Claremont
Phone 9284 5885



Midland

St John of God Hospital
1 Clayton Street, Midland
Private Hospital Entrance,
Ground Floor
Phone 9284 5885



Appointment

Date _____

Time _____



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